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ITEM:15 per FH G-670 12/11/90 cm. -#23, part II 1

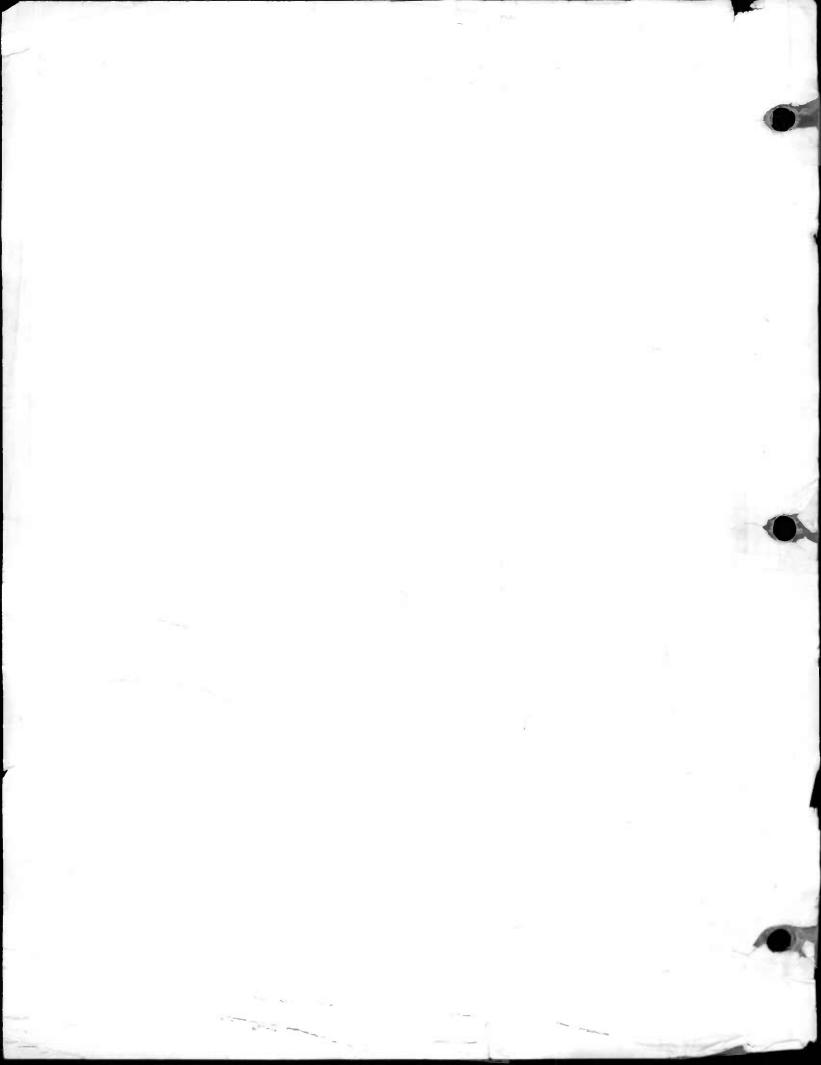
FINSERAN. JAMES L 01/05/41

34001

FOR FilmG681 11/8 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR kam CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 1990 YEAR DAY James Lawrence Finneran II MONTH 07 11;27 P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 216-38-2920 MONTHS DAYS HOURS MIN Jan. 6, 1941 Md . 49 1 🗶 M 2 🗌 F YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE BALTIMORE CITY DIRECTOR THE JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Md. Harford Bel Air 1 YES 2 X NO FUNERAL 10s. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 307 Lassen Court 21014 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, stc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) • 12 years Manager Westinghouse 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Lawrence James Finneran Helen Borsella BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Lassen Court Bel Air, Maryland 21014 Sheila M. Finneran 20s. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☑ Cremation 3 ☐ Ramoval from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State Green Mount Dec. 13, 1990 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY James F. Gladden James). Gladden Leonard J. Ruck Inc. 5305 Harford Road 21214 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, auch as cardiec or reapiretory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between organ tailore syndrome IMMEDIATE CAUSE (Final Multi-organ failare Onset and Death diseese or condition___ Acute 50% DUE TO (OR AS A CONSEQUENCE OF): resulting in death) and ida s Jante CERTIFICATION fromme Week. Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF) If sny, leading to immediate MIONIC Alcoholic cause. Enter UNDERLYING exa CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO History COMPLETION OF CAUSE OF DEATH? 1 | YES 2 1 - YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Reeldence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED Natural 5 Pending м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide determined 29a. CERTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and manner as stated 29b. SIGNATURE AND TITUE OF CERTIFIER 29c. LICENSE NUMBER 29d, OATE SIGNEO (Month, Day, Year) BE 990 44 (m) MEDICAL RESIDENT 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) OF MEDICINE JOHNS HOPKINS BALTIMORE HOSPITAL 31. DATE FILED (Month, Day, Year)
DEC 1 1 19 , 32. REGISTRAR'S SIGNATURE 1990 in Davidson Alandelle





3. TIME OF DEATH

6. BIRTHPLACE (State or Foreign Country)

4:14 A.M. M

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

216 12 2825 1 M 2 X Sa. FACILITY NAME (If not institution, give street and number)

4. SOCIAL SECURITY NUMBER

Gladys Othelia Swartz Figgs

5. SEX

1 🗆 M 2 😾 F

| 2, 3 s | CTOR | Pikesville Nursing Home Pikesvil | | | | | | | | lle Baltimore County | | | |
|--|---|---|---|--|-------------|---|-----------------------------|---------------------------|-----------------|-----------------------------------|-----------------|-----------------------------------|--|
| Pages 1, | ш | 10a. STATE | 10b. COUNTY | 1 | T | 10c. CITY, TO | OWN OR LO | OCATION | | | | 10 | Dd. INSIDE CITY LIMITS? |
| F. Pa | DIR | Maryland | В | altimore | | F | ikes | ville | | | | 1 | YES 2 NO |
| Б | RAL | 10e. STREET AND NUMBER | | | | | | 10f. ZIP CODE | | | | | AT COUNTRY? |
| transit | FUNE | Pikesville Nursing Convalescen | | | | | _ | 21208 | | | | J.S.A | |
| burial-transit permit. | | 1 Never Married 2 Married FORCES? 1 YES 2 | | | 2 NO | O If yes, specify Cuben, Maxican, Puerto Rican, etc.) Bla | | | | | Black, V | - American Indian, White, atc. | |
| as the | BY | 3 Widowed 4 □ Divo | road | IF TES, GIVE WAN ON I | DATES | | , , | YES 2 NO Specifi | y: | | | Specify: | White |
| nse a | ETED | 15. DEC (Specify onl | | (Give | EDENT'S USL | done during | PATION g most of working | 10 | 6b. KIND OF BUS | SINESS/INDU | JSTRY | | |
| Ď | | Elementary/Secondary (0 | 1-12) | College (1-4 or 5+) | . mo. L | on 1000 IO [OOD] | , | | | Cotton | M:11 | | |
| detached once. | COMPL | 17. FATHER'S NAME (First, M | iddle, Last) | | 1 | 16. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | 1.5 | | |
| 8 E | ш | James Russell Swartz Gustavus Cameron | | | | | | | | | - | | |
| 5 should notified | TO B | 19a. INFORMANT'S NAME (| | | 19b. | b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | |
| page 5 | ۴ | Charles Ham | | | | RFD 1 Worton Maryland 21678 | | | | | | | |
| ector, pa | | 20s. METHOD OF DISPOSIT 1) Burlal 2 Crematic | n 3 🗆 Ram | oval from State | other plac | (8) | | of cemetery, crematory or | | | CATION — C | | |
| | | A | 4 Donation 5 Tother (Specify) Good Shepherd Cemetery Ellicott City, Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | , Maryland | |
| e tuneral di al. examiner | | Burgee-Henss Funeral Home 3631 Falls Road, Baltimore, Maryl | | | | | | | | | | | |
| n by the removal. | \dashv | 23. PART I. Enter the d | Market VI | complications that cause | perc | th. Do not | 363 | 1 Falls Ro | oad, | Baltim | ore, | Mary | |
| | | shock, or I | and fallure. | List only one cause on | each line. | tii. Do not | oricor tire | mode of dying, suc | JII ale Ca | ardiac or reapi | retory arre | rat, | Approximate interval Between Onset and Death |
| # 6 B | | disease or condition resulting in death) a. Cardiac areat | | | | | | | | | Chaet and Death | | |
| | | resulting in death) | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| burial, | N | Sequentially list conditions, Due TO JOR AS A CONSEQUENCE OFI: | | | | | | | | | | | |
| ysician and o prior to buni traumatic | ATI | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | 1.te | | |
| e g | IFIC | CAUSE (Disease or injuthat initiated events | CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A GONSEQUENCE OF): | | | | | | | | | | |
| attending phy ntal Hygiene I ry, or other | CERTIFICATION | reaulting in death) LAST d. Domenta A 12huem | | | | | | | | | | | |
| E Meh | | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | |
| ed by | ICAL | | Penal | calculi | | 17.00 | | | | PERFOR | | C | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| been signed I pt. of Health a 3 shows any | MEDI | | | | | | | | | | OC. | | F DEATH? |
| has bee Dept. o | | | | | | | | | | | | | ~ |
| rtificate has he State Dep or item 23 | PHYSICIAN: | 25. WAS CASE REFERRED T | O MEDICAL | HOSPITAL: | | To | THEM: | 6. PLACE OF DEATH (CA | | | | | |
| | 1YS | 1 YES 2 DEO | | 1 Inpatient 2 ER/Out 28s. DATE OF INJURY | | DOA 4 | Mursing | Home 5 Residence | Y | ther (Specify) DESCRIBE HOW II | N III III OOO | LIDED | |
| ter this cath with narked, | | Natural 5 | Pending | (Month, Day, Year) | | INJUR | 777 | WORK? | 200.0 | PEŞCRIBE NOW II | NJUNT OCC | UNED | |
| After death |) BY | 2 Accident 3 Suicide | towestigation Could not be | 28e. PLACE OF INJUR | TY — At hom | ne, farm, stree | | | | OCATION (Street 8 | and Number | or Rural Rot | ute Number, |
| s after | TE | 4 Homicide | determined | butiding, etc. (Sp. | өскү) | | | | ٠ | ity or Town, State) | | | |
| 3 Suicide 4 Homicide 8 Could not be determined 286. PLACE OF INJURY — At home, farm, street, factory, office 287. LOCATION (Street and Number of City or fown, State) 288. PLACE OF INJURY — At home, farm, street, factory, office 288. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 280. LOCATION (Street and Number of City or fown, State) 281. LOCATION (Street and Number of City or fown, State) 282. LOCATION (Street and Number of City or fown, State) 283. LOCATION (Street and Number of City or fown, State) 284. LOCATION (Street and Number of City or fown, State) 285. LOCATION (Street and Number of City or fown, State) 286. LOCATION (Street and Number of City or fown, State) 286. LOCATION (Street and Number of City or fown, State) 287. LOCATION (Street and Number of City or fown, State) 288. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, State) 289. LOCATION (Street and Number of City or fown, S | | | | | | | | | | ed. | | | |
| | | | | | | | | | | ata and place, an | d due to the | e cause(a) s | and manner as stated. |
| HE FU | ш | 296. SIGNATURE AND TITE | OF CERTIFIE | RA May | | | | 29c. LICENSE NU | MBER | , | | | Nonth, Day, Year) |
| 2 2 3 NAME AND ADDRESS OF PERSON WHO COMPLETED CHIEF OF DEATH OFFIN 29 (200 ONE) | | | | | | | | | 2-1 | 0-90 | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (NEW 27) Type, Print) | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 1 | | nec 11 | 1990 | 32. REGISTRAR'S SIG | Noutro | No. | | | | | | | |
| 題 題 | | De Barton | | , | | plant. | | | | _ | | | DHMH-16 Rev 1/89 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

IF UNDER 1 YEAR IF UNDER 24 HRS.

9b. CITY, TOWN OR LOCATION OF DEATH

DAYS

6. AGE (In yrs. last birthday)

2. DATE OF DEATH MONTH December

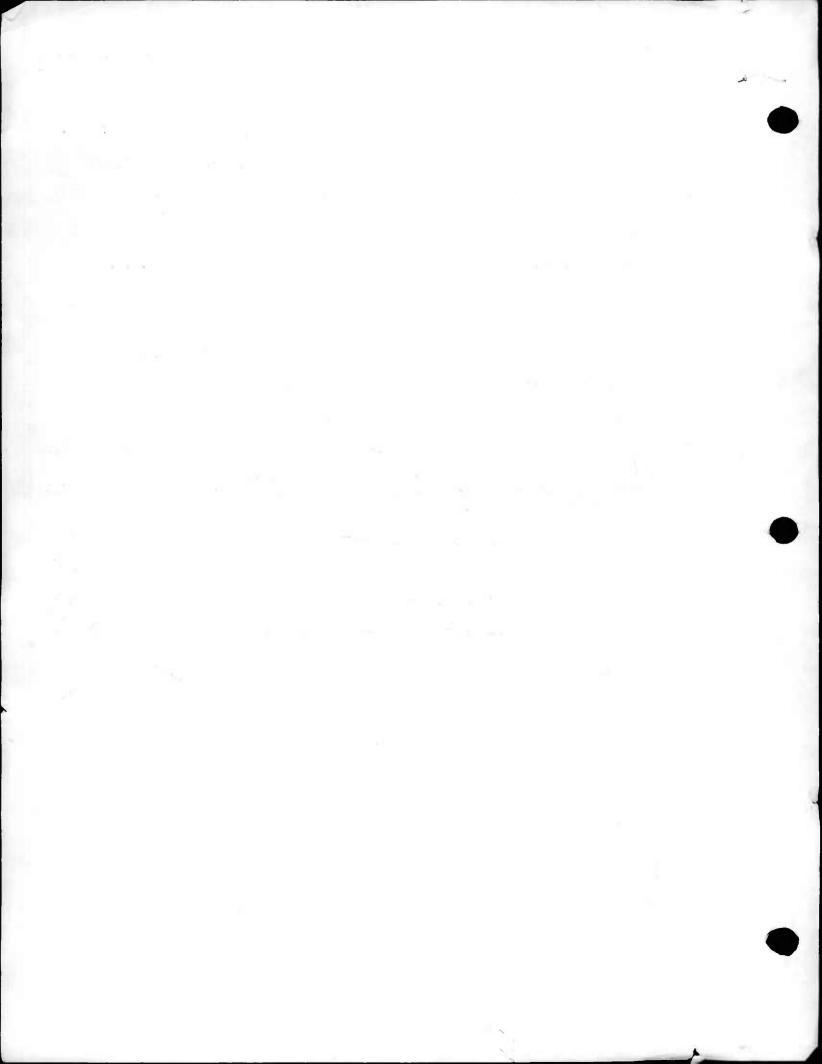
7. DATE OF BIRTH (Month, Day, Year) Sept 4,

DAY

1909

1990

909 Maryland

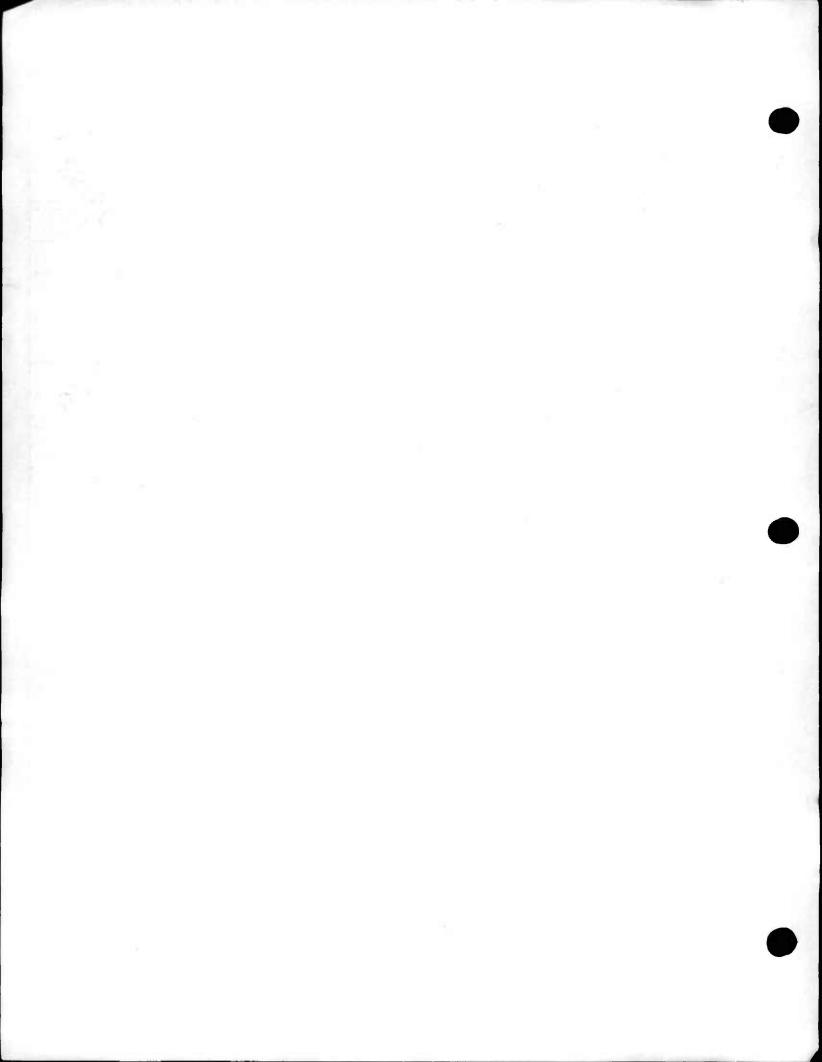


TO BE COMPLETED BY FUNERAL DIRECTOR

DEC 11 1990

32 DEGISTRAR'S CHANATURE

| | 1 - STATE OF STATE OF | MARYLAND C | / DEPAR | ICATE | OF I | EALIH AND N DEATH | | I YGIEN I IEG. NO. | | | |
|----------------------|---|---|--|--------------|----------------|----------------------|--|------------------------------|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Christopher | Р. | | Fabisz | | | 2. DATE OF | -90 DA | , | YEAR | 3. TIME OF DEATH 6:15PM M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 8. AGE (In yrs. i | | IF UNDER 1 Y | _ | IF UNDER 24 HRS. | 7 DATE OF I | ырты | | 8. BIRTHP | LACE (State or Foreign |
| | 215-70-5242 1 RM 2 🗆 F | 32 | YRS. | MONTHS D | AYS | HOURS MIN. | Jan. | 9 7 9 | 58 | MA Y | yland |
| | 9e, FACILITY NAME (If not institution, give street and number) | | | 9b. CITY, TO | OWN OF | LOCATION OF DE | | 7, | | TY OF DE | + |
| ۳ ا | 1102 Meridene Road | | | | Bal | timore (| City | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIRECTOR | Md. 10b. COUNTY HArfo | ord & | 10c. CIT | Y, TOWN OR I | | ston | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NHO |
| A | 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | | | | 10g. CITI | ZEN OF W | AT COUNTRY? |
| 띮 | 3417 Widow's Care | | | | | 2104 | 7 | | USA | | |
| BY FUNERAL | 1 X Name Married 2 Married FORCES? | NT EVER IN U.S. 1 YES 2 WAR OR DATES | | | | | | | e or No- 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 입 | 15. DECEDENT'S EDUCATION | | | USUAL OCCI | | | 16b. Kil | ND OF BUS | INESS/IND | | |
| <u> </u> | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 1 | 5+) | life. Do NOT u | | | | | | | | |
| MP. | 12th | As | sita | nt Ho | ors | e Train | ner | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | | | | _ | |
| BE | Joseph G. Fabisza | | | | | | leano | | | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | | Number or Rural F | | | | | 0.47 |
| | Joseph M. Fabiszak | 1 000 00 00 | | | | 's Care | e ral | | _ | City or Tow | |
| | 1 ◯XBuriel 2 ☐ Cremelion 3 ☐ Removal from State | other S ± | place) Stan | iela: | n or com | Cemete: | r 57 | | | | Md. |
| | 4 □ Donation 5 □ Other (Specify) | _ DC | , b can | 22. NA | ME AN | D ADDRESS OF FA | CILITY | Di | 11 (1 | mor c | rid. |
| | Connelly Fune | ralf | lom | Cor | nne | llyFun | eralH | | | | ve.21221 |
| | 23. PART I. Enter the disease, or complications to shock, or heart wildere. List only one or immediate CAUSE (Final disease or condition resulting in death) a. NARCO DUE 1 | ause on aach il | ALCO | HOL IN | | | h as cardiad | or respi | retory sn | rest, | Approximate interval Batwesn Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PERFORMED? AMAILABLE PR COMPLETIY ORDERTIY) | | | | | | | | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sum \) NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | | |
| SIC | EXAMINER? HOSPITAL: 1 Inpatient 2 | ER/Outpatient | 3 DOA | OTHER: | | 5 2 Kesidence | | Specific) | | | |
| | 27. MANNER OF DEATH 28a. DATE (Month) 1 Natural 5 Pending 28a. DATE | | 28b. TI | | 8c. INJI WO | URY AT RK? | 28d. DESCR | | NJURY OC | ALCOH | UBJECT USED |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not be determined in the determined | ig, etc. (Specify) | OF INJURY — At home, farm, street, factory, office | | | | 281. LOCATION (Street end Number or Rusul Route Number, ROAD BALLI INORE) CITY, MARYLAND | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best MEDICAL EXAMINER: On the basis of | | | | | | | | | |) end manner as stated. |
| E C | 29h, SIGNATURE AND TITLE OF CERTIFIER | | | - | | 29c. LICENSE NU | MBER | - | 29d. DA | TE SIGNED | (Month, Day, Year) |
| TO BE | MAME AND ADDRESS OF PERSON WHO COMPLETED C | AUSE OF DEATH | ITEM 273 /5~ | on Print) | | OCME | | | • | 12-7 | -90 |
| | MARGARITA A KORFTI MD | and an arming (| (19% | | | nn Stroc | | | | | |



| BALTIMORE, MARYLAND | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mouns after death. Page 6 may be retained by the host | TO THE FUNEAR DATECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | ion, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | equires that the death certificate be executed within 2 | en signed by the attending physician and completely | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene pnor to bunal, cremation, or removal. | hows any injury, or other traumatic event, th |
| ISION OF VITAL RI | ATTENDING PHYSICIAN: The law re | ECTÚR: After this certificate has bee | 's after death with the State Dept. (| n 28 is marked, or item 23 si |
| ā | TO THE HOSPITAL OF | TO THE FUNERAL DAME | be filed within 72 hours | IMPORTANT: If item |

| | FOR STATE 1 - STATE REGISTRAR | E OF MARYLAND / I | DEPARTMENT OF H RTIFICATE OF | | NTAL HYGIENE REG. NO. | 90 3 | 34004 | | | |
|-------------------|---|---|---|--|---|---------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) TH 4. SOCIAL SECURITY NUMBER 5. SEX | OMAS EDWARD (MAS EDWARD (6. AGE (in yrs. lest t | OREE Dirthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. | DATE OF DEATH MONTH 12 // DATE OF BIRTH (Mighth, Day, Year) | 4. BIRTHPLA | TIME OF DEATH SO M CE (Stata or Foreign | | | |
| 8 | 9e. FACILITY NAME (If not institution, give street and n | 2 = 73 73 1+65 Pit Ail | | R LOCATION OF DEATH | 16/24/17 | UNTY OF DEATH | ALABAMA | | | |
| FUNERAL DIRECTOR | | DENCE OF DECEDENT 10b. COUNTY BALTIMORE 10c. CITY, TOWN OR LOCATION 10c. | | | | | | | | |
| JNERAL | 804 well | 804 Wellington Rd 2/2/2 USA | | | | | | | | |
| B | 1 Name Mandad NO Kitambad FOR | CES? XXYES 2 NO ES, GIVE WAR OR DATES WWII | tf yee, sp | city Cuben, Mexicen, Po 2 NO Specify: | | Specify: | WHITE | | | |
| COMPLETED | (Specify only highest grade completed | (Give | e kind of work done during mo Do NOT use retired.) Salesman | | Wholesale | | | | | |
| Sol | 17. FATHER'S NAME (First, Middle, Last) | · | | | (First, Middle, Malden Sumame) | | | | | |
| BE (| Carl C. Green Sr. | Lan | | Nellie 1 | | | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Thomas E. Green Jr. | | Western Control in the | | e Number, City or Town, State, Z e. Marvland | 14 | | | | |
| | Thomas E. Green Jr. 2603 Ivy Place Baltimore, Maryland 21234 20a, METHOD OF DISPOSITION 1 X Burlel 2 Cremetton 3 Removat from State other (Specify) 4 Donetton 5 Other (Specify) Dulaney Valley Memorial Gardens Lutherville, Maryland | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home | | | | | | | | | |
| | Dennis Stephen X | | | | ad Baltimore | | | | | |
| | 23. PART I. Enter the disease, or compiles shock, or haert failure. List only IMMEDIATE CAUSE (Finsl | y one cause on each line. | | | s cardiac or reepiratory e | rreet, | Approximata interval Between Onaat and Desth | | | |
| | disease or condition resulting in death) a. CARDIOGEMIL SHOCK DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| NOI | Sequentially liet conditions, If sny, leading to immediate b. HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 3 | CAUSE (Disease or Injury | DUE TO (OR AS A CONSECU | T PMEUN | DHECT | MY | | | | | |
| CERTIFICATION | | ARCINO MA | | | | | | | | |
| , L | PART II. Other eignificent conditions contri | buting to death but not re | euiting in the underlyin | g ceuse given in Par | rt I. 24a. WAS AN AUTOPS | Y 24b. WE | RE AUTOPSY FINDINGS | | | |
| S | POST-UBSTRU LUCULATED | ICTIVE PIME | 4 MOMIX | | 1 TYES 2 NO | co | MPLETION OF CAUSE DEATH? | | | |
| PHYSICIAN: MEDICA | LUCULA TED | EMPYEMA | + | | - | 1 [| YES 2 NO | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | SITAL: | 28. P | ACE OF DEATH (Check | only one) | | | | | |
| IX | 1 YES 2 NO 1 I Inp | patient 2 ER/Outpatient 3 | DOA 4 Nuraing Hor | IURY AT 26 | Other (Specify) 8d. DESCRIBE HOW INJURY O | CCURED | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) Ie. PLACE OF INJURY — At hon | M t | PRK? YES 2 NO | Bf. LOCATION (Street and Numb | | n Number | | | |
| ETED | 3 Suicide 8 Could not ba 4 Homicide determined | building, etc. (Specify) | ne, term, attest, tectory, one | | City or Town, State) | rai or riarai rioue | e reumon, | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On the | the best of my knowledge, dea e basis of examination end/or in | | leath occured at the tim | ne, date end piece, end due to | the ceuse(a) ar | | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIERA | Cla fr. | 14-0. | D - (5 | 8 74 29d. D. | ATE SIGNED (M | onth, Day, Yeer) | | | |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPI LOPE T: VILLA | JR. MID. | 120 914 | TER PIER | ere brive, | Towa | M MD. | | | |
| | 31. OATE FILED (Month, Day, Year) 32 DEC 1 1 1990 | REGISTRAR'S SIGNATURE | Andies. | | | | | | | |
| | e | D | | | | | DUMU 16 Day 1/80 | | | |

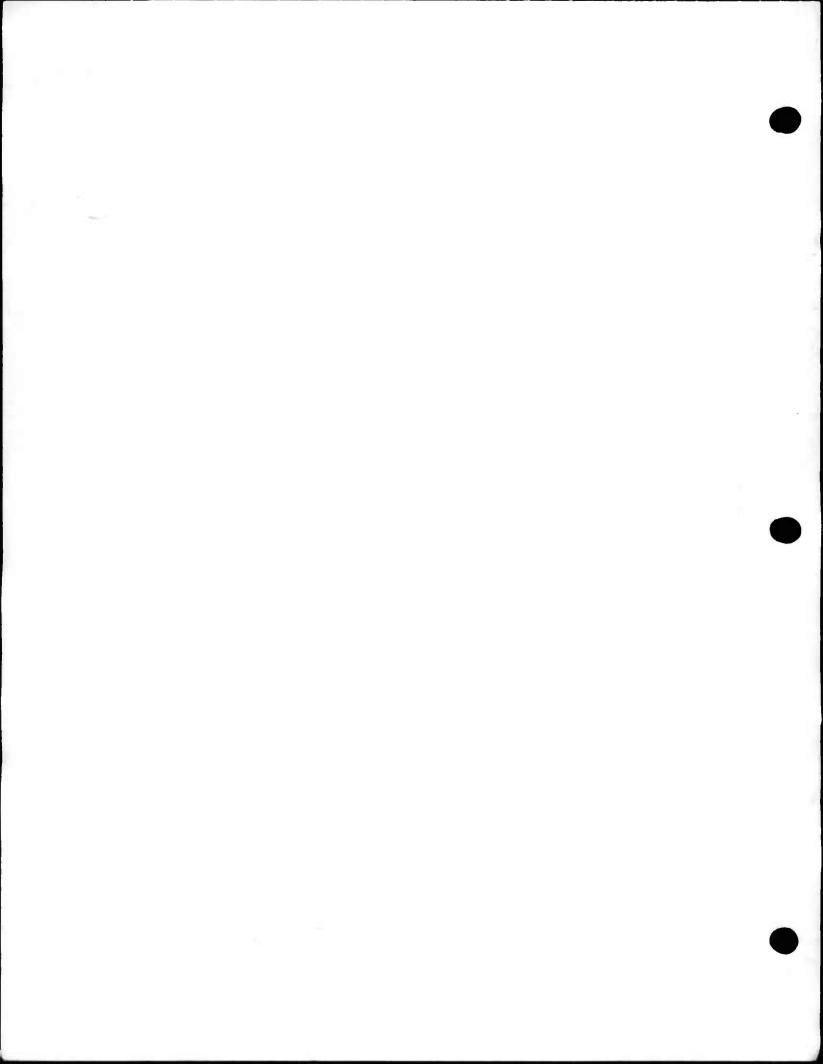
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90 34005 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTA | | | | GIENE G. NO. | 90 34005 | | | |
|--|--|---|---|---------------------------|---|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) BOROTHY | L. GR | ABARE | K | | 2. DATE OF DE | | SEAR 3. TIME OF DEATH | | | |
| | | SEX 6. AGE (III | | UNDER 1 YEAR NTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIS (Month, Day, | Year) | BIRTHPLACE (State or Foreign | | | |
| OR | 9a. FACILITY NAME (If not institution, give street FRANCIS SCOTT KE | and number) EY MED C | 77R, | | TIMBE | | - | TIMORE | | | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY | 7 | | OWN OR LOCAT | ON | | | 10d. INSIDE CITY | | | |
| [D | 10e. STREET AND NUMBER | IMORE | | UNDA 101. | 101. ZIP CODE | | | 1 YES 2 NO | | | |
| IER/ | 2719 Southbroo | | | 2122 | 2 | US | A | | | | |
| BY | 11. MARITAL STATUS 12. 1 | U.S. ARMED 2 NO TES | ARMED 13. WAS DECENDENT OF HISPANIC ORI If yee, specify Cuben, Maxican, Puer 1 YES 2 NO Specify: | | | | | | | | |
| COMPLETED | | ON pleted) ollege (1-4 or 5 +) | 18e. DECEDENT'S US (Give kind of work life. Do NOT use n | done during mos | STRY | | | | | | |
| MP | 10th | | Hous | ewife | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) Leroy Lawrence | | | | 18. MOTHER'S NA | | na Schwa | v + 0 | | | |
|) BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AC | ORESS (Street e | | | y or Town, State, Zlp C | | | | |
| 5 | Edward Grabare | k | 2719 | South | brook 1 | Road E | altimor | e Md.21222 | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal 4 Donetion 5 Other (Specify) | from State | other place) | | emetery 20c. LOCATION — City or Town, State Baltimore Md. | | | | | | |
| | 21. BIONATURE OF FUNERAL SERVICE LICENS | | / | | O ADDRESS OF FA | CILITY | Darti | 21222 | | | |
| | Connelly Fu | mist | lome | | | | | f Dundalk | | | |
| | 23. PART i. Enter the diseases, or com shock, or healt silure. Liet | only one cause on as | tha daeth. Do not ich line. | enter tha mo | da of dying, suc | h as cardiac c | or reepiratory erree | intervai Between | | | |
| | IMMEDIATE CAUSE (Fine) disease or condition resulting in deeth) a. Reval Faclure / month | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| S | Sequentially list conditions, If any, leading to immediate Due to (or as a consequence of): | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events | Prodonos DUE TO (OR ASA | consequence of: | ac Resuscitation Efforts | | | | /month | | | |
| ËRT | resulting in death) LAST | | | | | | | | | | |
| CAL | PART II. Other significant conditions of | ontributing to death bu | ut not resulting in | the underlying | ceuse given in | | WAS AN AUTOPSY PERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| PHYSICIAN: MEDI | | | | | | _ | / | 1 TYES 2 NO | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (Ch | eck only one) | | J | | | |
| YSIC | | OSPITAL: Inpetient 2 ER/Outpe | | THER: Nursing Hom | e 5 🗆 Residence | 8 Other (Spe | city) | | | | |
| | 27. MANNER OF DEATH 1 Naturel 5 Pending | (Month, Day, Year) | 28b. TIME (| Y WO | URY AT RK? 'ES 2 NO | 28d. DESCRIB | E HOW INJURY OCCU | RED | | | |
| ED BY | 2 Accident Investigation 3 Suicide S Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Speci | — At home, ferm, stre | | | 281. LOCATION City or Tox | (Street and Number of vn, State) | reet and Number or Rural Route Number, tate) | | | |
| COMPLETED | 204 CERTIFIER | N: To the best of my knowl | edge, death occurred | at the time, date | end place, end due | to the cause(e) | end menner es atatec | J. | | | |
| Ö | Amal . | In the beels of examination | end/or investigation, | in my opinion, d | esth occured at the | the time, date end piece, end due to the ceuse(e) end menner ee ststed. | | | | | |
| 296. SICHATURE AND TITLE OF CERTIFIER 290. LICENSE NUMBER | | | | | | | | 29d. DATE SIGNED (Month, Day, Year) | | | |
| 5 | 36. NAME AND ADDRESS OF PERSON WHO C | | ATH (ITEM 27) (Type, Pi | int) | 1)32 | 587 | /2 | 2-16180 | | | |
| | JETTY J. DOTE | ey, N.D. | 4940 | Easki | n Hve, | Baet. | MD 212 | 24 | | | |
| | DFC 7 1990 | Julia Davidson | -Mandalla | | | | | | | | |



FOR STATE REGISTRAR

1. OECEDENT'S NAME (First, Middle, Last)

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| 1314 | executed |
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| O. BO | certificate |
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| S | the |
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| 3ECO | requires |
| | AM. |
| ₹ | The |
| DIVISION, OF VITAL RECORDS, P.O. BOX 13146 | OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed w |
| /ISION | ATTENDING |
| 5 | OR |
| | OSPITAL |

7. DATE OF BIRTH (Month, Pay, Year) 1 X M 2 F Pages 1, 2, 3 should 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH MICHAEL DIRECTOR 10c. CITY, TOWN OR LOCATION 10a STATE 10d. INSIDE CITY ALT 1 NES 2 NO permit. 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? FUNERAL thst 21218 funeral director, page 5 should be detached for use as the burial-transit urs after death. Page 6 may be retained by the hospital or attending physician. 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yea or NoIf yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 ND Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 HOD IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorced COMPLETED 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only hig entary/Secondary (0-12) College (1-4 or 5+) AGricultural Farmer 17. FATHER'S NAME (First, Middle, Last) 255€ TRdVes Hunt notified at ouvenia BE 19a. INFORMANT'S NAME (Type/Print) 2 BALTO MO 21201 DOROTHY FRAYES the medical examiner must be 20a. METHOD OF OISPOSITION

1 D Burlal 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Nat 20c. LOCATION - City or Town, Stata 4 Donation 5 D Other (Specify) NAME AND ADDRESS OF FACILITY PUR 21, SIGNATURE OF FUNERAL SERVICE LICENSEE Russ F. H JOSEPH hi Russ Voseph BALTIMORE MA 21216 . DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the i hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart failure. List only one cause on each line. Interval Retw **Onset and Deeth** IMMEDIATE CAUSE (Final disease or condition ONGESTIVE resulting in death) or other traumatic event, DIAE TO (DR AS A CONSEQUENCE OF) THEROSCLEROTIC CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEDUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury 1315EASE QUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMARABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? BIRUCTIVE PERFORMED! rulmon ARY shows any 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26, PLACE OF OEATH (Check only one HOSPITAL: OTHER: 1 YES 2 NO 1 Department 2 ER/Outpatient 3 DOA ng Home 5 🗆 Residence 8 🗆 Other (Specify) 6 27. MANNER OF DEATH 28a. DATE DF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d, OESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending м 1 YES 2 NO BY 2 Accident Investigation 26e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 60 COMPLETED 4 Homicide 28 Tem 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my know TO THE HOSPITAL O
TO THE FUNERAL DI
Be filed within 72 ho
IMPORTANT: If ite 2 MEDICAL EXAMINER: On th 29b SIGNATURE AND TITLE DF CERTIFIER 29c LICENSE NUMBER Day, Year) BE D285 6 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) "ASNEEM 7220 HEICHTI 10 MD 212 32. REGISTRAN'S SIGNATURE 31. DATE FILED (Month, Day, Year) 1990 greha DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

IF UNDER 1 YEAR

YRS.

DAYS

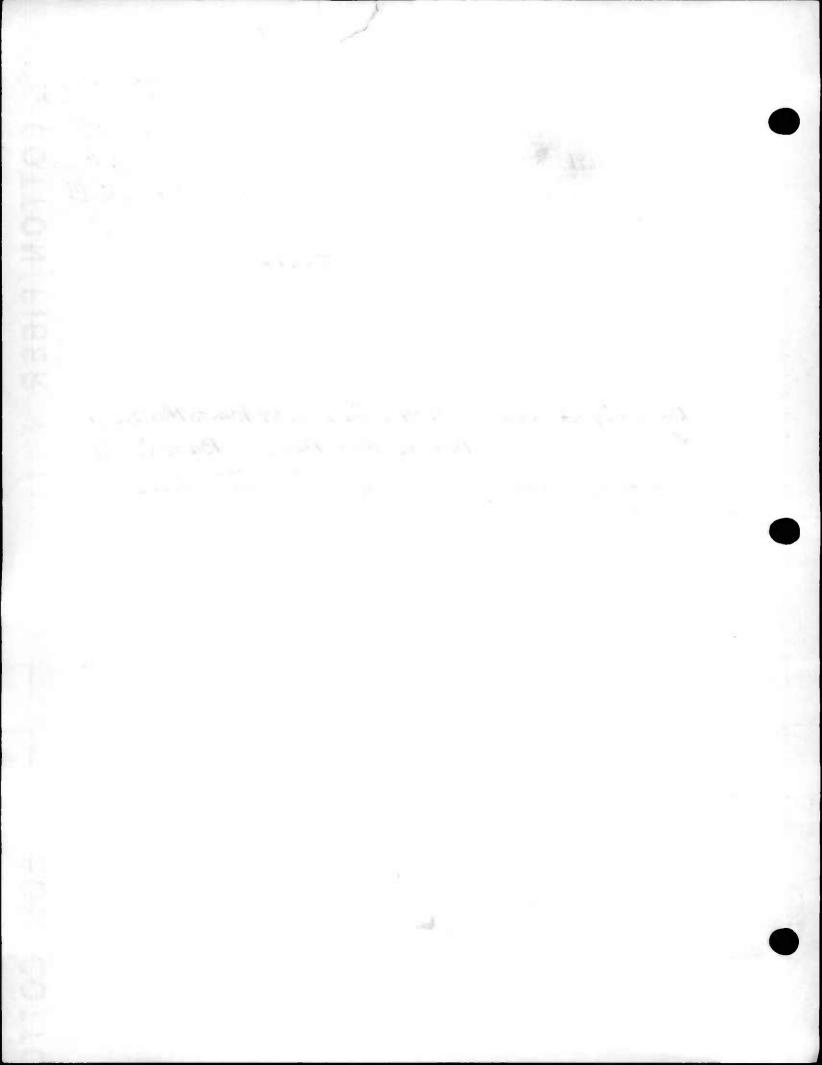
IF UNDER 24 HRS.

REG. NO.

34

8. BIRTHPLACE (Sta

2. DATE OF DEATH



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Mrs after death. Page 6 may be retained by the hospital or attending physician.

TO THE FINNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146

1 - FOR STATE REGISTRAR

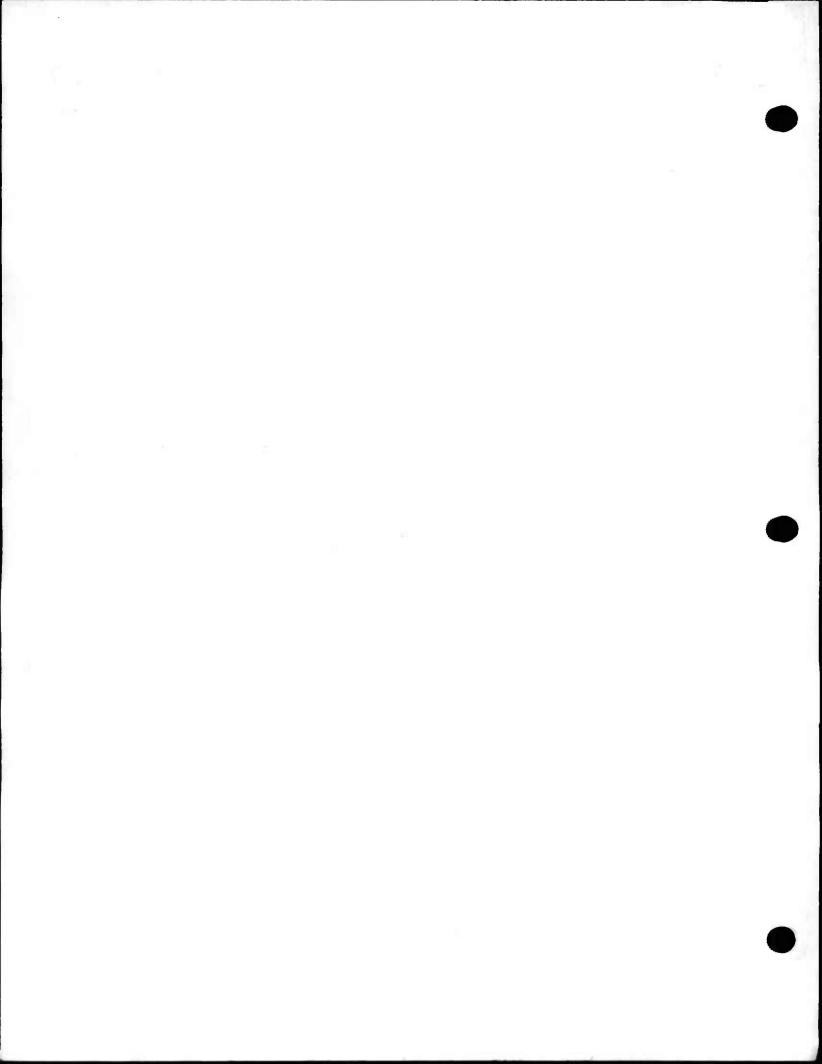
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO

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| | TIEGIOTTOWY | | | | | | | <u> </u> | DEATH | | HEG. NO. | | | |
|--|--|-------------------------|---------------------------|---------------------------|-------------|--------------|--------------|----------|----------------------|---------------|--|------------|------------------|---|
|) | 1. DECEDENT'S NAME (First | Middle, Last) | | | | | | | | 2. | DATE OF DEATH MONTH DA | v | YEAR | 3. TIME OF DEATH |
| | FRANCIS TIMOTHY GALLANT DECEMBER 9, 1990 9:55A | | | | | | | | | | 9.55A M | | | |
| ı | 4. SOCIAL SECURITY NUME | | 5. SEX | 8. AGE (II | n yrs. last | birthday) | IF UNDER 1 1 | /EAR | IF UNDER 24 HI | RS. 7. | DATE OF BIRTH | . 1 | 8. BIRTI | IPLACE (State or Foreign |
| | 010 00 17 | 0.7 | 1. XM 2 - F | | | | | DAYS | HOURS MI | N. | (Month, Day, Year) | | Count | (v) |
| | 213 32 17 9e. FACILITY NAME (If not in | | | | 55 | | ah CITU T | DWA! C | OR LOCATION O | | 2-25-34 | | MARY NTY OF 0 | LAND |
| ا ج | | | | | | [] | | | | PEATH | ' | - 111 | | |
| DIPECTOR | 1214 Willo | | aa | | | | שעו | nda | alk | | | Ral | time | ore |
| 3 | 10e, STATE | 10b. COUNTY | r | | | 10c. CITY. | TOWN OR | LOCAT | TION | | | | | 10d. INSIDE CITY |
| | MARYLAND | | | | | | | | | | LIMITS? | | | |
| | | Di | ında | | | | _ | | | 1 TES 2 NO | | | | |
| | 100. STREET AND NUMBER 1214 Will | | | 101 | . ZIP CODE | | | 10g. CIT | IZEN OF | WHAT COUNTRY? | | | | |
| | | 5W 10 | aa | | | _ | | | 2122 | 22 | | U.S | S.A. | |
| | 11. MARITAL STATUS | | 12. WAS OECEDEN | T EVER IN | U.S. ARM | MED | | | | | ORIGIN? (Specify Yee uerto Rican, etc.) | or No- | 14. RACI | E — American Indien, k, White, etc. |
| | 1 Never Merried 2 X | | IF YES, GIVE | | | 0 | | | | pecify: | uerto Rican, etc.) | | Spec | |
| | 3 Widowed 4 Dive | orced | 6-3-57 | - 5 | -18- | -59 | | | | | | | WHIT | TE . |
| ı | 15. DEC | EDENT'S EDU | CATION | | 16e. DEC | CEDENT'S U | SUAL OCC | UPATIO | ON ost of working | | 18b. KIND OF BUS | INESS/IN | DUSTRY | |
| ı | | | College (1-4 or 5 | +) | Him. | Do NOT use | retired.) | ing mo | IST OF WORKING | | 1 | | | |
| ŀ | 11th grade | ∍ ′ | | | Plu | mber | • | | | | Krick | Plu | mbe | r |
| | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | | 18. MOTHER'S | S NAME | (First, Middle, Malden | | | |
| | FRANK GAL | | | | | | | | | WA. | | | | |
| | | | | | 401 | MAII INO 1 | DDDESS : | Ohm -4 | | | | - Ctro- | in Carlot | |
| | Shirley Le | eto Ga | allant | | | | | | | | e Number, City or Tow | | | 03035 |
| | | | | | | | | | | | or. Balt | | | |
| | 20e. METHOD OF DISPOSIT | ION | oval from State | | other pla | ce) | | | metery, crematory | | | | | own, State |
| | 4 Donation 5 Other | (Specify) | | Sa | | | of | Je | esus 1 | L2/J | L1/9b Ba | alti | mor | e, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS | | | | | | | ND ADDRESS O | F FACILI | TY | | | | | |
| | 1 | 1 | 20 | _ | 0 | | Duc | ia- | -Ruck | Fur | neral Ho | ome | of I | Dundalk, I |
| | - VC | N. | 1.0 | α | | - | 79: | 2.2 | Wise | Ave | e. Balto |)., | Md. | 21222 |
| 1 | 23. PART i. Enter the d | | complications the | | | | t enter ti | ne mo | de of dying, | auch e | a cerdiec or reepi | ratory ar | reat, | Approximate |
| 1 | IMMEDIATE CAUSE (Fi | | Liet offiny offe ca | use on ea | ocn iina. | | | | | | | | | Onaet and Death |
| 1 | disease or condition 10 YEARS | | | | | | | | | | | | | |
| 1 | reaulting in death) | | | | | | | KU. | INOMA | | | | | TO TEARS |
| l | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | Sequentielly list conditions, Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| | If any, leeding to imme ceuse. Enter UNDERLY | | | , | | | | | | | | | | |
| | CAUSE (Disease or inju | | C | A 24 RO) (| CONSEC | UENCE OF) | | | | | | | | - |
| | thet initiated events reaulting in death) LAS | T I | | (e.i.ne n | 20.1020 | - Live of | | | | | | | | |
| | XX | | d | | | | | | | | | | | |
| | PART il. Other algnifica | ant condition | ne contributing to | death b | ut not r | esulting in | the und | erlyin | g cause give | n in Pai | rt i. 24a. WAS AN | AUTOPSY | 24 | b. WERE AUTOPSY FINDINGS |
| | CACHEXIA, | | | | | _ | | , | _ | | PERFOR | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | _CACREATA, | _COTO. | -CU TAMEUL | O EI | 0101 | ın | | | | | 1 TYES 2 | □ NO | | OF DEATH? |
| | | | | | | | | | | | _ | | | 1 YES 2 NO |
| | | | | | | | | | | | | | | |
| | 25. WAS CASE REFERRED | TO MEDICAL | | | | | | 28. P | LACE OF DEAT | H (Check | only one) | | | |
| 1 | EXAMINER? 1 YES 2 NO | | HOSPITAL: 1 Inpatient 2 | ☐ ER/Outo | atient 3 | DOA | OTHER: | | ne 5 🗆 Reside | nce 8 F | Other (Specify) | | | |
| | 27. MANNER OF DEATH | | 28e. OATE O | FINJURY | | 28b. TIME | OF 2 | Bc. IN. | JURY AT | | d. DESCRIBE HOW I | NJURY O | CCURED | |
| 1 | 1 Natural 5 | Pending | | Day, Year) | | INJU | | W | ORK? YES 2 N | | | | | |
| 1 | 2 Accident | Investigation | 20- 81 405 | OE IN IT IN | _ &s L- | ma form | med 4s -1 | | | _ | H LOCATION *** | and M | ar ar B | Courte Muse's |
| | 3 Sulcide 8 4 Homicide | Could not be determined | 28e. PLACE building | of Injury , atc. (Spec | — At no | me, rerm, at | rmat, factor | y, offic | C-B | 20 | St. LOCATION (Street of City or Town, State) | ena Numbe | er or Hural | rioute Number, |
| | - Intrinciale | Jesellini Peu | | | | | | | | | | | | |
| - | 29e. CERTIFIER (Check only | TIFYING PHYS | ICIAN: To the best of | ot my know | ledge, de | ath occurred | at the tim | e, dete | e end piece, en | d due to | the cause(a) and ma | nner ee st | ated. | |
| 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(a) and manner ee stated. | | | | | | | | | | | | | | |
| 1 | | - | | | | | • | | | | | | | |
| 29d. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | | |
| | fere | - 1 | | | | | | | | | | D , | ECEM | BER 10, 1990 |
| 1 | 30. NAME AND AODRESS C | F PERSON WI | HO COMPLETED CA | USE OF DE | ATH (ITE | M 27) (Type, | Print) | | | | | | | |
| | PETER V. | JUÝAN | | | | CH PO | INT F | ROA | D FORT | HOW | ARD, MAR | YLAN] | D 2 | 1052 |
| | 31. DATE FILED (Month, Day | Year) | 32 REGISTA | | | | | | | | | | ** | |
| | DEC 11 199 | 90 Au | la Devidson | Mone | | | | | | | | | | |
| | DEC 1 1 199 | 30 gu | lia Devidson | Mode | | | | | | | | | | |



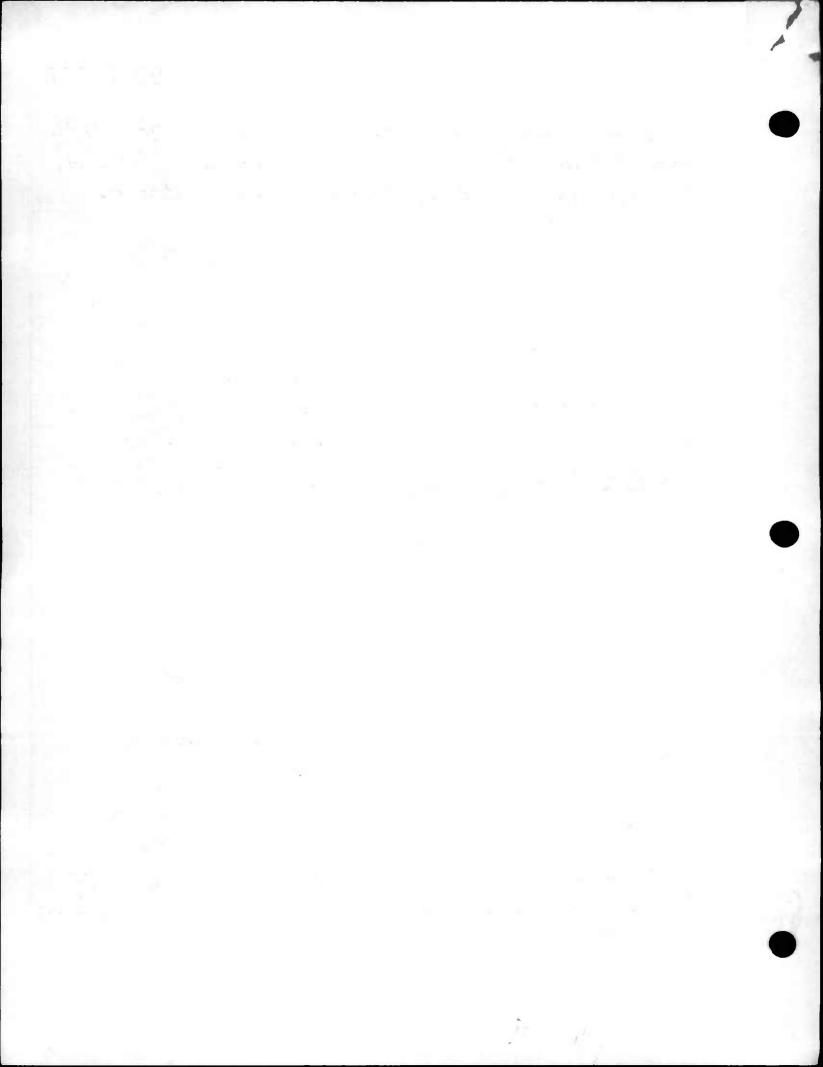


THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 fours after death. Page 6 may be retained by the hospital or attending physician.

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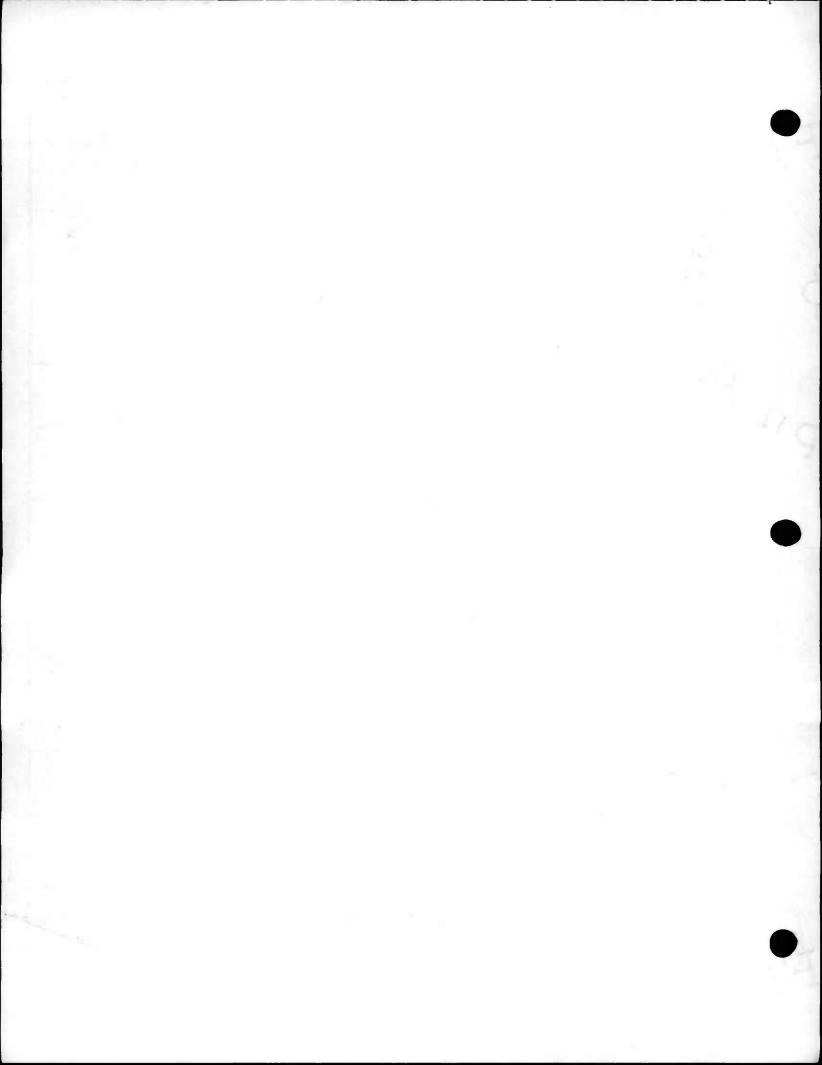
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | NT OF HEALTH AND | MENTAL HYGIENE REG. NO. | 0 34000 | | | | |
|--|---|---|--|--|---|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 15E GIL | LISPIE | | 2. DATE OF DEATH DAY | YEAR 73A M | | | | |
| | 220-18-5222 | 1 - M 2 OF 6 | 4 THS. MONTH | 10.01 | 7. DATE OF BIRTH (Month, Day, Year) | e. BIRTHPLACE (State or Foreign Country) Indiana | | | | |
| TOR | 9a. FACILITY NAME (If not institution, give stre | els Hosp | | DWSON | M) BA | HTO. | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | imore | Dunda | NLOR LOCATION | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ▼ NO | | | | |
| FUNERAL | 10e. BTREET AND NUMBER 215 S. Woodwell | Avenue | | 101. ZIP CODE 21222 | | en of what country? ed States | | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Olvorced | 12. WAS DECEOENT EVER IN FORCES? 1 YES IF YES, OIVE WAR OR DA | 2 XNO | 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico 1 — YES 2 NO Specif | | 14. RACE — American Indian, Black, White, etc. Specify: White | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work do life. Do NOT use retire | CEDENT'S USUAL OCCUPATION ve kind of work done during most of working Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| E COMP | 12th grade 17. FATHER'S NAME (First, Middle, Lest) Lawrence Humphr | n/a eys | Secretar | 18. MOTHER'S NA | Glass Inc AME (First, Middle, Melden Surneme) 1 Smiley | dustry | | | | |
| TO BE | 19a INFORMANT'S NAME (Type/Print) Velson L. Gillis | pie | | | Route Number, City or Town, State, Zip Ave. Balto., I | | | | | |
| 20a. METHOD OF DISPOSITION Name of cometery, crematory or | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE COOK | | | uneral Home ovenue Balto. | | | | | |
| | 23. PART I. Enter the diseases, or co shock, or haert failure. Li | | d the death. Do not er | | | Approximate interval Between | | | | |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | LUNG OUE TO (OR AS A | CANC A CONSEQUENCE OF): | ER-me | TASTATIC | Onset and Daeth | | | | |
| ATION | Sequentially list conditions, If any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | A CONSEQUENCE OF): | | | | | | | |
| CAL | PART II. Other significant conditions | contributing to death b | out not resulting in the | underlying cause given in | Part I. 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| : MED | | | | | | OF DEATH? | | | | |
| PHYSICIAN: | | HOSPITAL: | | 28. PLACE OF DEATH (CHER: Nursing Home 5 Residence | Maca | rc. | | | | |
| | 27. MANNER OF OEATH 11 Natural 5 ☐ Pending | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 26d. DESCRIBE HOW INJURY OCC | | | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF INJUM building, etc. (Spec | F INJURY — At home, farm, street, factory, office 26f. LOCATION (Street and Number or Rural Route Number | | | | | | | |
| COMPLET | anal anal | | | | e to the cause(a) and manner as state e tima, date and place, and due to the | | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | Ulexande | evro | 29c. LICENSE NU 027 | | SIGNED (Month, Day, Year) | | | | |
| | CARLAS. ALE | COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, Print) | | 4 VALLEY RO- | Towsen - MA-21204 | | | | |
| | DEC 11 1990 July | 32 REGISTRAR STORE | ALIES . | | | | | | | |



| | FOR STATE REGISTRAR | STATE OF MARYLANI | D / DEPARTM | | | ENTAL HYGIENI REG. NO. | | 34009 |
|----------------------|--|--|--|---------------------|---|---|--------------------|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | ROBERT B. | GC | ODMAN | D 2 | ECEMBER 9 | , 199° | 3. TIME OF DEATH 9:45 A. M |
| | The state of the s | 5. SEX 6. AGE (In yrs | | UNDER 1 YEAR | IF UNDER 24 HRS. 7 HOURS MIN. M | ATE OF BIRTH (Month, Day, Year) IARCH 22, 1 | .913 A. 5 | BIRTHPLACE (State or Foreign Sountry) IARYLAND |
| OR | 99. FACILITY NAME (If not institution, give stre 411 WHEATON PLACE | et and number) | 96 | CATONS | R LOCATION OF DEAT | TH . | 9c. COUNTY BALT | OF DEATH CIMORE |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY MARYLAND BAI | LTIMORE | 10c. CITY, TO | CATON | on SVILLE | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| FUNERAL | 100. STREET AND NUMBER 411 WHEATON PLACE | APT I | | 101. | ZIP CODE | | | OF WHAT COUNTRY? |
| à l | | 12. WAS DECEDENT EVER IN U.S. FORCES? 1X YES 2 IF YES, GIVE WAR OR DATES | □ NO | If yes, spe | ENDENT OF HISPANIC city Cuban, Mexican, 2 X NO Specify: | ORIGIN? (Specify Yas Puarto Rican, atc.) | | RACE — American Indian, Black, Whita, atc. Specify: WHITE |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elamentary/Secondary (0-12) | | a. DECEDENT'S USI (Give kind of work life. Do NOT use re CHEF | done during mos | N It of working | FOOD IN | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) GEORGE GOODMAN | | I | | MOLLY | CALLAHAN | 1 | |
| 욘 | 190. INFORMANT'S NAME (Type/Print) VIRGINIA GOODMAN 200. METHOD OF DISPOSITION | (WIFE) | 411 WHI | EATON P | LACE API | | ATONSVI | ILLE, MD.21228 |
| | 1\(\) Buriel 2 \(\) Cremation 3 \(\) Remote 4 \(\) Donation 5 \(\) Other (Specify) | val from State LOU | JDON PARI | CEMET | ERY | BAI | TIMORI | E, MARYLAND |
| | Luarece | anisk | < | 1630 E | DMONDSON | AVENUE, CA | TONSVI | FUNERAL HOMES LLE, MD.21228 |
| | 23. PART i. Enter the diseases, or co ahock, or heart feilure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) | DUE TO (OR AS A CO | maton | 4 | Λ | netatati | | Interval Batween |
| CERTIFICATION | Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A CO | INSEQUENCE OF): | | | | | |
| ERTIFI | that initiated events resulting in death) LAST | DUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other eignificent conditions | contributing to death but | not resulting in | the underlying | g cause given in P | art i. 24s. WAS AN PERFOI 1 YES : | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatie | | THER: | ACE OF DEATH (Chec | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | OF 28c. INJ Y WO | Decimal and Decimal | 28d. OESCRIBE HOW | INJURY OCCUP | NED |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, stre | et, factory, offic | | 281. LOCATION (Street City or Town, State | | Rural Route Number, |
| COMPLETED | Check only | CIAN: To the best of my knowled: R: On the basis of examination a | | | and the second second | | | and the second s |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Munin | ٧ | | DOZO | | 29d. DATE S | V 10/8 C |
| | 30. NAME AND ADDRESS OF PERSON WHO MORTON ELLIN M. | D. 5310 OLD | COURT RO | AD, RANI | ALLSTOWN | , MARYLAN | D 211 | 33 |
| | 31. DATE FILED INOTIC DON YOU 1990 | 32- A STEPASE OF COST | ADE MONTON | | | | | |

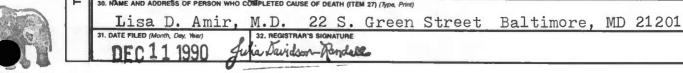




| 46, |
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| 13 |
| BOX |
| P.O. |
| ORDS, |
| - RECOR |
| VITAL |
| OF |
| DIVISION |
| |

| TO THE MOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2~ vours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page being the page of the permitten |
|---|
|---|

| | FOR | TATE OF MADY | AND / DEDAI | THENT | OE U | FAITU AND B | MENTAL HYGIENI | 9 | 0 3 | 34011 | 0 |
|----------------------------------|--|--|-------------------------------|--------------------------|------------|---------------------|---|------------|--------------------|-------------------------------------|----------|
| | 1 - STATE REGISTRAR | IAIE UF MART | CERTIF | | | | MENIAL NIGIENI REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | - | | | | 2. DATE OF DEATH | | | 3. TIME OF DEA | тн |
| - 1 | E1 | izabeth | Sara | Godn | nan | | MONTH DA | | 90 | 5:42 | Ам |
| 1 | | | (In yrs. last birthday) | IF UNDER 1 | YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | IPLACE (State or F | |
| | 218-27-5711 | M 2 X F | YRS. | | DAYS | HOURS MIN. | (Month, Day, Year) 01/24/0 | 90 | Countr | γ) | |
| | 9a. FACILITY NAME (If not institution, give street in | and number) | | 101 | .2 | R LOCATION OF DE | | | NTY OF O | ryland | |
| ۱ ا | | | מידו | * C. C. I. | | | AID | | | | |
| 2 | Franklin Square | HOSPILA | T E.K. | | | ssex | | Da | . L U L | more | |
| DINECTOR | 10e. STATE 10b. COUNTY | | 10c. Cl | TY, TOWN O | R LOCAT | ION | | | | 10d. INSIDE CITY | Y |
| 5 | Maryland B | altimore | | | | Esse | x | | | LIMITS? | NO |
| | 10e. STREET AND NUMBER | | | | 101. | ZIP CODE | | 10g. CIT | IZEN OF V | VHAT COUNTRY? | |
| LONGHAL | 34 High Seas Co | urt | | | | 21 | 221 | | USA | Δ | |
| 5 | | WAS DECEDENT EVER | IN U.S. ARMED | 13. W | WAS DEC | | IIC ORIGIN? (Specify Yea | or No- | | | lan. |
| | 1 X Never Married 2 Married | FORCES? 1 YES | 2 XINO | 16 | yes, spe | city Cuban, Mexica | n, Puerto Ricen, etc.) | | | E — American Indi k, Whita, atc. | |
| 0 | 3 Widowed 4 Divorced | IF TES, GIVE WAN ON | DATES | ' | ☐ ¥E3 | 2 NO Specify | r: | | Speci | Whit | е |
| 3 | 15. DECEDENT'S EDUCATION | | 16a. OECEDENT | S USUAL OC | CUPATIO | N | 16b. KIND OF BUS | INESS/INI | DUSTRY | | |
| COMPLETED | (Specify only highest grade comp Elementary/Secondary (0-12) Co | oleted) ollege (1-4 or 5+) | (Give kind of life, Do NOT | work done duse retired.) | luring mo | at of working | | | | | |
| 7 | | N/A | | N/A | | | | N | I/A | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | 11/ 11 | | 11/ 4. | | 18. MOTHER'S NA | ME (First, Middle, Maiden | | , | | |
| | Earl Arthur | Godman | | | | Jenni | fer Bell | ۵ ا | ROW | ling | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | Godinari | 19b. MAILIN | G ADDRESS | (Street a | | Route Number, City or Town | | | T T112 | |
| 2 | Earl A. Godman | | | | | ct. | | | 2122 | 1 | |
| 1 | 20a. METHOD OF DISPOSITION | 2 | 0b. PLACE OF DISPO | | | | | | City or To | | |
| | 1 K Burial 2 Cremation 3 Removal | from State | Meadowi | | | | | | | | |
| | 4 Donation 5 Other (Specify) | 5E | Meadowi | | | D ADDRESS OF FA | | TKT.1 | .dge | , IVILD | |
| | 21. stand on the service servi | Than The | | Ma | acNa | abb Fun | eral Home | e. F | .A. | | |
| | George E. Ma | cNabb | | | | | ck Rd. I | | | MD 21 | 228 |
| | 23. PART I. Enter the diseases, or com | plicetions thet ceus | | | | | | | | Approxim | - |
| ı | ahock, or heart fellure. List | only one cause on | each line. | | | | | | | Interval E | |
| | IMMEDIATE CAUSE (Final disease or condition | / Besnit | the E | ailin | 0 | | | | | | d Doddii |
| | resulting in death) a. | DUE TO (OR AS | A CONSEQUENCE | AI JUIC | _ | | | | | - | |
| | | Totaloo | 4 of F | 1/4 | | | | | | 1 2 | 4 |
| CERTIFICATION | Sequentielly list conditions, b | DUE TO (OR AS | A CONSEQUENCE | 6/JUF | - | | | | | DIT | 7 |
| = | If any, leading to immediate cause. Enter UNDERLYING | Trachen | 4 trong 1 | 70000 | lont | · Aires | (. | | | hine | 6 |
| 5 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE | DELICION | 40/11 | villac | 9 | | | 0117 | // |
| | resulting in death) LAST | Frata | 1-1/2521 | Duck | 1/20 | (/) | , | | | hinsh | , |
| ֭֝֟֜֜֝֟֜֜֓֓֓֓֓֓֓֓֓֓֜֟֜֜֓֓֓֓֓֓֓֓֟ | d | 1 (UII LES I | - NUCESCO I | Dyoj | 1100 | 2708 | | | | 1011 111 | |
| | PART II. Other algnificant conditions co | ontributing to death | but not resulting | In the un | dertyln | g cause given in | Part I. 24s. WAS AN PERFOR | | 246 | . WERE AUTOPSY | |
| 3 | | | | | | | 1 _ YES 2 | | | AVAILABLE PRIOR COMPLETION OF | |
| | | | | | | | | 22 | | OF DEATH? | NO. |
| 2 | | | | | | | _ | | | (159 Y | NO |
| 2 | 25. WAS CASE REFERRED TO MEDICAL | | | | 28 PI | ACE OF DEATH (Ch | anck only one) | | | | |
| PHYSICIAN: MEDICAL | EXAMINER? | OSPITAL: | A | OTHER | 3: | | | | | | |
| | 27. MANNER OF DEATH | 28a. DATE OF INJUR | | | 28c. INJ | | 8 Other (Specify) 28d. DESCRIBE HOW I | N ILIPY OF | CHRED | | |
| | 1 🔀 Natural 5 🗌 Pending | (Month, Day, Year | 1 | NJURY | WO | RIC? | 200. DESCRIBE NOW I | NJOH! OC | CONED | | |
| 0 | 2 Accident Investigation | 290 BI ACE OF IN III | DV At home for | -1 | | ES 2 NO | | | | | |
| 3 | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, etc. (S) | pecify) | , street, fect | огу, оптіс | | 28f. LOCATION (Street a City or Town, State) | | or of Hural | rioute Number, | |
| | | | | | , | | | | | | - |
| COMPLE | 29a. CERTIFIER 1 X CERTIFYING PHYSICIAN | t: To the best of my kn | owledge, death occu | rred at the ti | lme, dete | and place, and due | to the cause(a) and mai | nner as st | nted. | | |
| 5 | one) 2 MEDICAL EXAMINER: 0 | n the basis of examina | tion and/or investiga | tion, in my o | pinion, d | eath occured at the | time, data and place, ar | nd dua to | the cause(| (a) and manner as | stated. |
| | 296. SIGNATIONE AND TITLE OF CERTIFIER | | | | | 29c. LICENSE NU | MBER | 29d. DA | TE SIGNE | O (Month, Day, Year | r) |
| 100 | Theanal | 1 | 11) | | | | | • | | 07/90 | |
|) I | CONTRACTOR OF ANY CO | | | | | | | | | | |



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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | person on attraction purveional. The low comings that the death configurate the executed within |
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|-------------|---|---------------|--|--|------------------------|--|---|---------------------------------|--|
| | | | FOR STATE REGISTRAR | TATE OF MARYLAND / CE | | OF HEALTH AND I | MENTAL HYGIENI REG. NO. | E | |
| | | | 1. DECEDENT'S NAME (First, Middle, Last) | 1 6 4 | 1 | | 2. DATE OF DEATH MONTH DA | YEAR | 3. TIME OF DEATH |
| 1/ | | | 4. SOCIAL SECURITY NUMBER 5. S | 71 | | | 7. OATE OF BIRTH | 90 | HPLACE (State or Foreign |
| | 모 | | NONE 10 | 1 42 VF 18 m/o | YRS. MONTHS | DAYS HOURS MIN. | (Monthy Day, Year) | Count | nder 3 |
| | 2, 3 should | FOR | 9a. FACILITY NAME (If not institution, give street a | husalal | 9b. CITY, | Town or Location of Di | NP | 9c. COUNTY OF D | EATH |
| | Pages 1, | DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN O | 4 | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | sit permit. | | 10e. STREET AND NUMBER | | 7010 | 10f. ZIP CODE | | 10g. CITIZEN OF N | |
| 146 | by the hospital or arenumy physicial. be detached for use as the burial-transit permit. Pages 1, at once. | BY FUNERAL | 1 Never Married 2 Married | WAS DECEDENT EVER IN U.S. ARI FORCES? 1 YES 2 YN FYES, GIVE WAR OR DATES | 0 1 | MAS DECENDENT OF HISPAI f yes specify Cuban, Mexica YES 2 NO Specifi | n, Puerto Rican, etc.) | or No- 14. RACI Blac Spec | E — American Indien, k, White, atc. |
| 3-3 | as th | | 15. OECEDENT'S EDUCATIO | N 16a DEC | EDENT'S USUAL OC | CLIPATION | 16b, KIND OF BUS | SINESS/INDUSTRY | RIANC |
| 21203-3146 | hed for use | COMPLETED | (Specify only highest grade comp | leted) (Gir | None | furing most of working | IGG. KIND OF BOS | megg/mboster | |
| MARYLAND | be detached for | ш | 17. FATHER'S NAME (First, Middle, Leet) LEONIOGS | | | | ME (First, Middle, Maiden | Surname) | |
| AR | 5 should | TO B | 19a. INFORMANT'S NAME (Type/Print) | 1 | | (Street and Number or Rural | | | |
| | | - | Patricia Bowling | | | S. Green S | | | |
| IMORE, MARY | lirector, p | | 20a, METHOD OF DISPOSITION 1 A Burlal 2 Cremation 3 Removal 1 4 Donetion 6 Other (Specify) | rom State | BURA | me of cemetery, cremetory or | | CATION — City or To | own, State |
| ALT | funera exami | | 21. SIGNATURE OF FUNERAL SERVICE LICENSE | C. Jos | | name and address of fa 511 ParkHe | Derri | | ones F.H. 215 |
| ш | ed in by the or removal medical | | 23. PART I. Enter the diseases, Dr comp | (cations that caused)the de | eth. Do not snter | the moda of dying, suc | h as cardiac or respi | ratory screat, | Approximate |
| | 3 o E | | IMMEDIATE CAUSE (Final | only one cause on each line | <u></u> | | | | Interval Between Onset and Death |
| | | | disease or condition | CAMPI | AV A | MESI | | | |
| 46, | 2 5 2 5 | | | DUE TO (OR AS A CONSEC | UENCE OF): | 1-10-6 | A 1 | 1 | |
| 1314 | and o | O | Sequentially list conditions, b | DUE TO (OR AS A CONSEC | UENCE OF): | 07 TO 12 | -theo/071 | 01 | |
| X | ysician prior t | CAT | if any, leading to immediats cause. Enter UNDERLYING | FRIGT | nach. | where A | Tresca | | |
| . B | ding physical ding physical displays of the principle of the principle of the | Ĕ | that initiated events | DUE TO (OR AS A CONSEC | UENCE OF): | | | | |
| P.0 | 5 5 0 | CERTIFICATION | resulting in death) LAST | | | | · · · · · · · · · · · · · · · · · · · | | |
| | | | PART II. Other significant conditions co | ntributing to death but not r | esulting in the un | derlying cause given in | Part I. 24e. WAS AN | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| RECORDS | turies trat the signed by the Health and M DWS any Injections | MEDICAL | | | | | 1 TYES 2 | 200 | COMPLETION OF CAUSE OF DEATH? |
| EC . | law requires is been sign ept. of Healt 23 shows | ME | | | | | | | 1 YES 2 NO |
| | | Ä | | 7 | | _ | | | |
| VITAL | ate ate | SICIAN: | | SPITAL: | OTHER | 26. PLACE OF DEATH (C) | neck only one) | | 1 |
| > | ertife Perti | PHYS | 1 YES 2 NO 1 TO 27. MANNER OF DEATH | Inpatient 2 ER/Outpatient 3 26s. DATE OF INJURY | 28b. TIME OF | sing Home 5 Residence | 6 Other (Specify) 28d. DESCRIBE HOW I | NJURY OCCUREO | |
| | this with | Y PI | 1 Netural 5 Pending | (Month, Day, Year) | INJURY M | WORK? | | | |
| DIVISION | after d | ED B | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26s. PLACE OF INJURY — At ho building, etc. (Specify) | me, farm, street, fact | ory, office | 281. LOCATION (Street City or Town, State) | and Number or Rural | Route Number, |
| 5 | To DOR | PLET | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN | To the best of my knowledge, de | ath occurred at the t | ime, data and place, and du | to the cause(s) and ma | nner as stated. | |
| | FUNERAL Within 72 MATH: IF | COMPL | Control City | the basis of examination and/or | | | | | (a) and manner ea stated. |
| | THE HOSPITAL THE FUNERAL filed within 72 PORTANT: If | ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NU | MBER | 29d. DATE SIGNE | D (Month, Day, Year) |
| 1 | TO THE HUSPILL TO THE FUNER PORTION THIS | 0 B | HI ho | | | | | 12 8 | 3 90 |
| | - | | 30. NAME AND ADMRESS DE PERSON WHO CO | MPI ETED CALISE OF DEATH //TEI | 4 273 (Tenna Defeat) | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

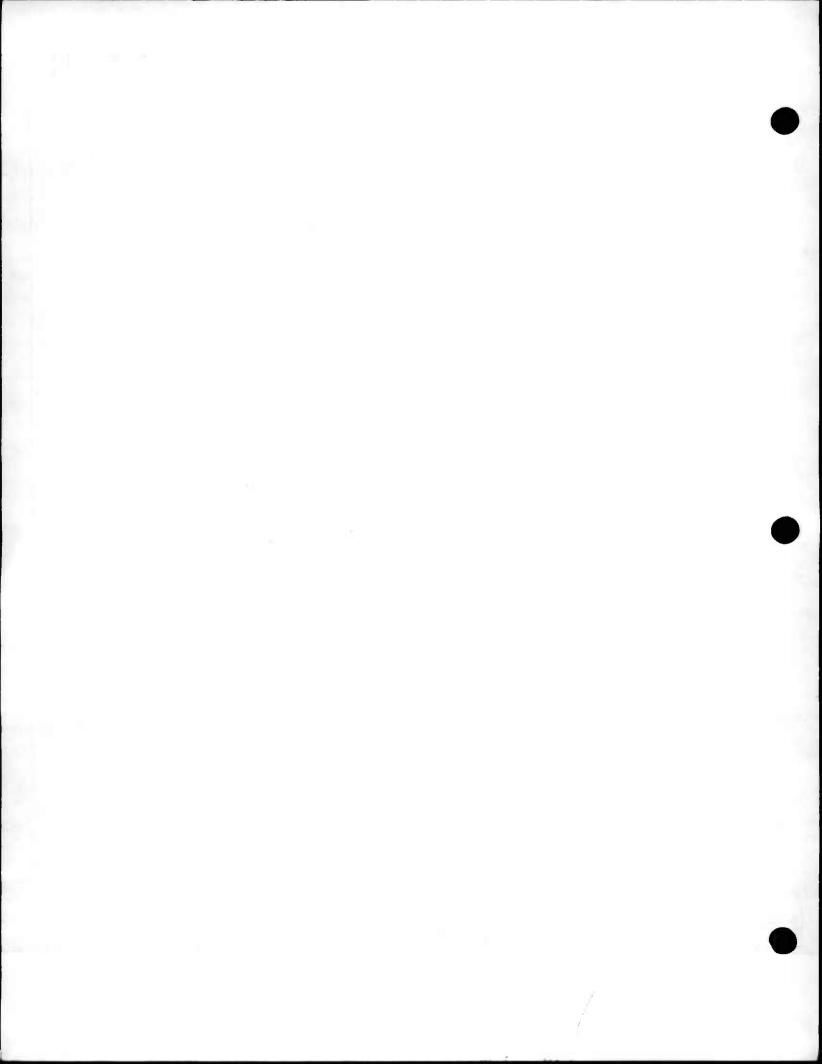
1990

31. DATE FILED (Month, Day, Year)

32. REGISTRAN'S SIGNATURE
Schie Davidson-Randelle



DHMH-16 Rev 1/89



for une as the burial-transit permit. Pages 1, 2, 3 should

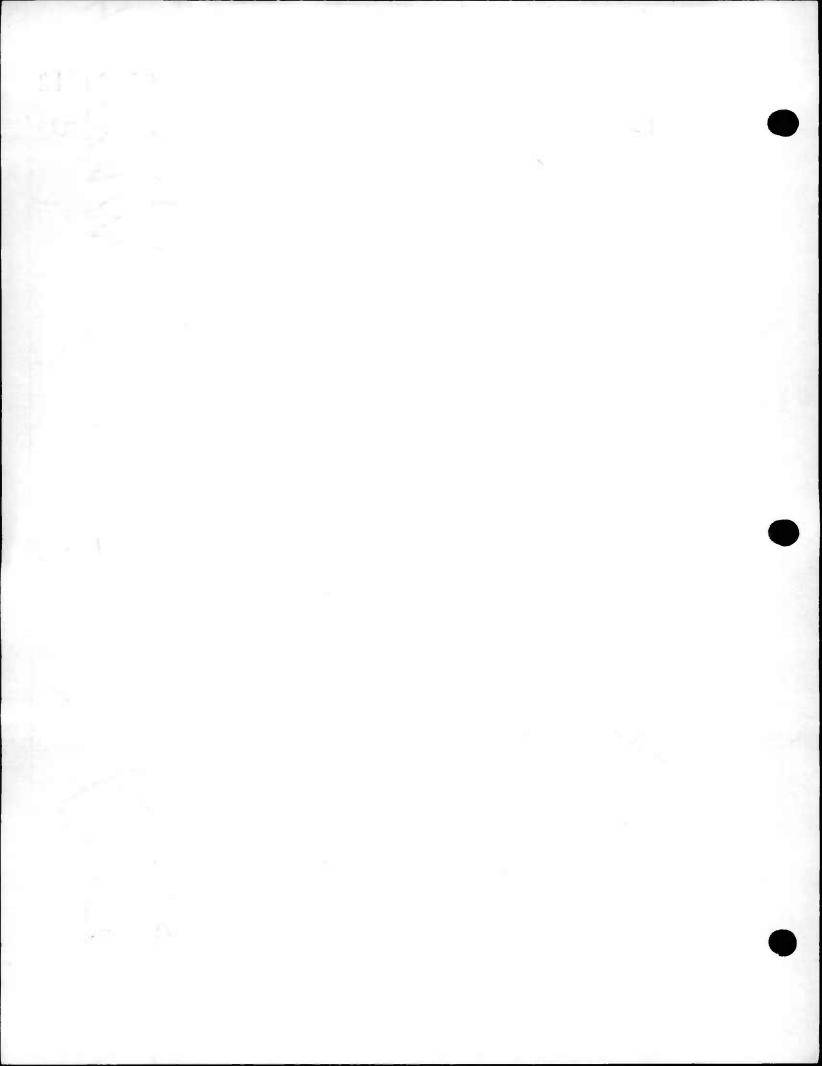
| | Ö |
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| | 57 |
| o, | within |
| 5 | executed |
| < | 2 |
| 0.00 | certificate |
| 7 | death |
| 2 | the |
| Ę | that |
| 5 | requires |
| | 100 |
| ₹ | Ę |
| 2 | PHYSICIAN |
| DIVISION OF VITAL RECORDS, P.O. BOX 13145 | IAI OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 10 |
| 5 | S |
| | 8 |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | NTAL HYGIENE REG. NO. | 90 | 34012 |
|-----------------------|---|---|---|--------------------------------|--|---|-------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last | DTT C | 7R05 | SM | AN | DATE OF DEATH DAY | 9 YEAR | 3. TIME OF DEATH P |
| | 4. SOCIAL SECURITY NUMBER 216-34-4606 9a. FACILITY NAME (If not institution, give | 1 XX 2□ # 5 | 3 YRS. | IF UNDER 1 YEAR ONTHE DAYS | IF UNDER 24 HRS. 7 HOURS MIN. | SEPT.1,19 | 96. COUNTY OF E | MARYLAND |
| CTOR | SINAI HOSPTIAL | | | 774 | TIMORE | | 3L 000111 01 1 | JEANN . |
| DIRECTOR | MARYLAND 106. COUN | BALTIMORE | 10c. CITY, | | ALLSTOWN | | | 10d. INSIGE CITY LIMITS? 1 AYES 2 NO |
| FUNERAL | 12 ALDERSGATE C | | | 10 | f. ZIP CODE 211 | | USA | WHAT COUNTRY? |
| B∡ | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS OECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | if yes, sp | CENDENT OF HISPANIC Hecity Cuban, Mexican, I | ORIGIN? (Specify Yes o Puerto Rican, etc.) | r No— 14. RAC Blac Spec | E — Americen Indian, ik, White, etc. ^{CHY} WHITE |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grac Elementary/Secondary (0-12) | | 16e. DECEOENT'S U (Give kind of wo life. Do NOT use EARNINGS | rk done during mo retired.) | oat of working | SOCIAL | | Y ADMN. |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) CANTOR HERBERT (| GROSSMAN | | | SARA | | ER | |
| 5 | 19a. INFORMANT'S NAME (Typo/Print) MRS. FRANCES GRO | | 12 ALD | ERSGATE | E CT. RAN | DALLSTOWN, | MD 211 | |
| | 20e METHOD OF DISPOSITION 1 (A Burial 2 Cremation 3 Red 4 Donation 5 Other (Specify) | 1 | other place) BETH TFI | | metery, cremetory or | | ATION — City or T ALTIMORE | |
| | 21. SIGNATURE OF FUNERIAL SERVICE L | telluar | | | ND ADDRESS OF FACIL LEVINSON REISTERS | & BROS.,1 | NC. BALTIMO | DRE,MD 21215 |
| CERTIFICATION | 23 PARTI. Enter the diseases, or shock, or heart failure immediate or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. BRA DUE TO (OR AS OUE TO (OR AS | A CONSEQUENCE OF: | MET | ASTAS BLAD | DER | CER | Approximata Interval Batween Onset and Death |
| PHYSICIAN: MEDICAL CE | PART II. Other significant condition | one contributing to death i | but not resulting in | the underlyir | g cause given in Pa | 24a. WAS AN A PERFORM | IED? | b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Check | | | |
| В | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b | 28a. OATE OF INJURY (Month, Day, Year) | 28b. THME INJU | OF 28c, IN W | JURY AT 2 ORK? YES 2 NO | 8d. OESCRIBE HOW IN. 81. LOCATION (Street an City or Town, State) | VA | Route Number, |
| COMPLETED | enel | /SICIAN: To the best of my know | | | | | | (a) and manner as stated |
| BE | 296. SIGNATURE AND TITLE OF CERTIF | THA | -1 | | 20c. LICENSE NUMB | | | D (Mofrett, Day, Your) |
| 10 | 30, NAME AND ADDRESS OF PERSON V | 1 SINA | 41 40 | SPIT, | 340,1 | = BAL | MH | ONE |
| | SI. DATE FILED (MACHE). Since (Macr) | 32 MEGISTRAD'S, SICH | NATURE OF A POPULATION | | ;; | -11 | | 1.14 |

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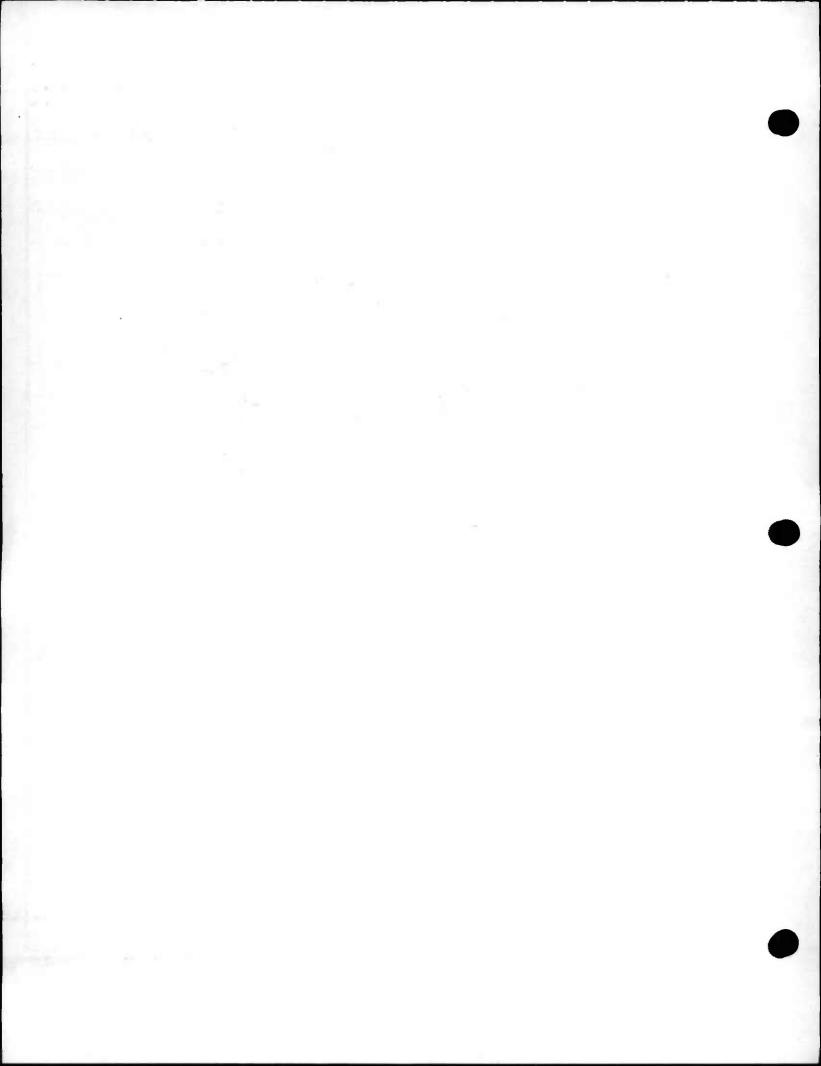
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DHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21203-3146 | 6 may be retained by the hospital or attending prince ctor, page 5 should be detached for use as more than | nust be notified at once. |
|--|---|---|
| BALTIM | y filled in by the funeral dire | tion, or removal. the medical examiner |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as an execution of the funeral director, page 5 should be detached for use as | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Hem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| DIVISION OF | TO THE HOSPITAL OR ATTENDING PHYSICI TO THE FUNERAL DIRECTOR: After this cert | be filed within 72 hours after death with the IMPORTANT: If Item 28 is marked, o |

| | 1 - FOR STATE REGISTRAR | OF MARYLAND A | DEPAR ERTIF | TMENT OF | HEALTH AND I | MENTAL HYGIE REG. N | | 90 34013 |
|---------------|--|--|--|--------------------------------|-----------------------------|---|---------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) BURTON | J. | 6 | ORDO | N | 12 - | 3 9 | S. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 12 M 2 | | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) 3/26/22 | | BIRTHPLACE (State or Foreign Country) MARYLAND |
| TOR | 9e. FACILITY NAME (If not institution, give street and num 2909 FALLSTAFF RD., AP RESIDENCE OF DECEDENT | | | | LTIMORE | ATH | 9c. COUNTY | OF DEATH |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND | | 10c. CIT | y, town or loc BALTI | | 1 | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| | 10e. STREET AND NUMBER | | | 1 | of. ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| BY FUNERAL | 1 Name Married 2 Married FORCE | CEDENT EYER IN U.S. A S? 1 YES 2 Q GIVE WAR OR DATES | RMED NO | If yes, a | | | fes or No— 14 | USA RACE — American Indian, Black, White, etc. Specify: WHITE |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1 | | ECEDENT'S Give kind of the Do NOT us OWN! | | TION nost of working | | R PHOTO | GRAPHY LAB. |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) SOLOMON GORDON | | | | | ME (First, Middle, Maid MINNIE R | en Surname) UDMAN | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) WILLIAM A. BEALE, ATTY | | | | | BALTIMOR | E, MD | 21230 |
| | 20e. METHOD OF DISPOSITION 1 Donation 5 Other (Specify) | | E OF DISPO Disco) | RAFL | emetery, crematory or | | BALTIMO | RE, MD |
| | 21. BIGHATURE OF JUNERAL SERVICE LICENSEE | ison | | | | SNY& BROS ERSTOWN R | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury | | EQUENCE O | ng C | | Leseas | | it, Approximeta Interval Between Onset end Death |
| MEDICAL | PART II. Other significant conditions contribu | ting to death but not | resulting | in the underly | ing ceuse given in | PERI | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | OTHER: | PLACE OF DEATH (C | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATH 28a. | DATE OF INJURY Month, Day, Year) | 28b. Til | ME OF 28c. | NJURY AT WORK? YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HO | W INJURY OCCU | RED |
| | 3 Suicide 26a. | PLACE OF INJURY — At I building, etc. (Specify) | home, farm, | street, factory, of | fice | 28t, LOCATION (Stre City or Town, St | eet and Number or ste) | r Rural Route Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the b | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | enter | 7 | 7.D. | 29c. LICENSE NU | 9317 | 29d. DATE | SIGNED (Month, Day, Year) 12/3/90 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLET | TED CAUSE OF BEATH (T | ГЕМ 27) (Тур | e, Print) | | | | 1 |
| | DEC 11 1990 | BELDER BRIMDIN | indulik | | | | | |

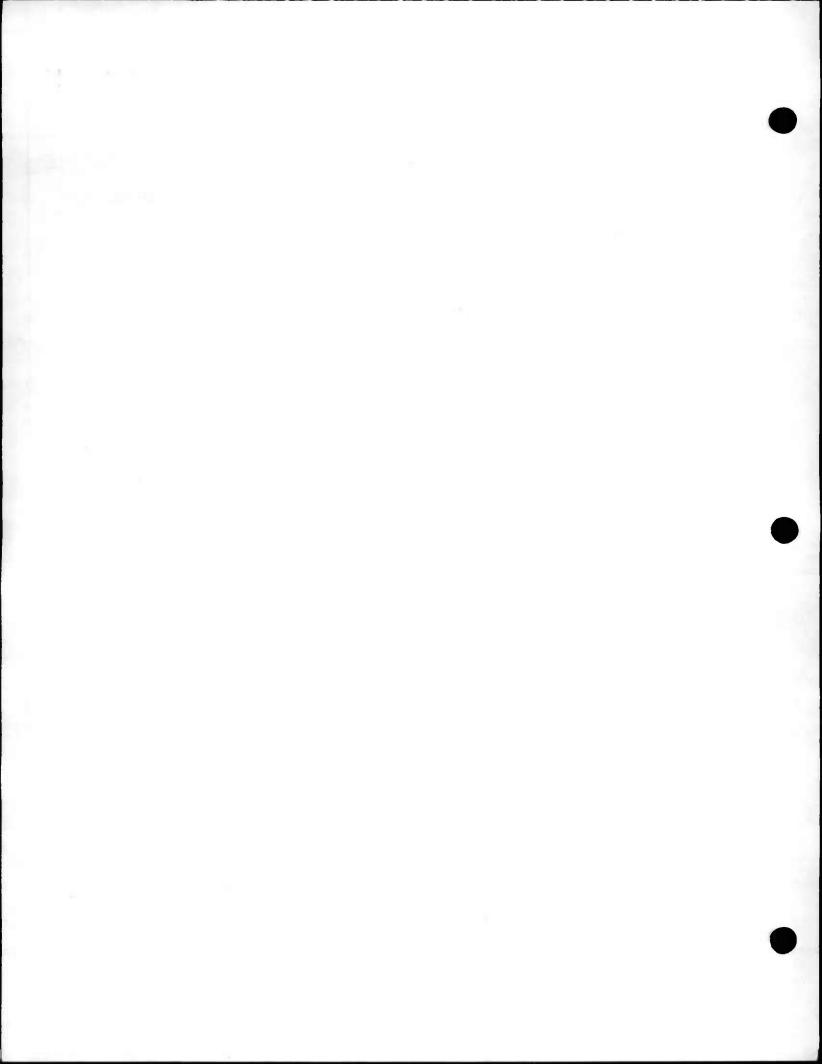


irmit. Pages 1, 2, 3 should

| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. |
| e funeral director, page 5 should be detache | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache |
| death. Page 6 may be retained by the hosp | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Lx. nours after death. Page 6 may be retained by the hosp |
| | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYI | | | | EALTH AND I | | YGIENE EG. NO. | 9 | 0 0 | 34014 |
|--------------------------|--|--|--|--|---|---|---|---|---|--------------------------------------|---|
| | 1. OECEDENT'S NAME (First, Middle, List) | | | GIL | SINGER | 2 | 2. DATE OF E MONTH 12 (| 06ATH DAY | YE | AR | 10:50 A M |
| | 4. SOCIAL SECURITY NUMBER 150-013919 | 5. SEX 8. AGE | E (In yrs. lest b | | NDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | JULY | URTH | 8. 8 | BIRTHPLAC | E (State or Foreign Jersey |
| NG. | 98. FACILITY NAME (If not institution, give s Franklin Squ | | tal | 9b. (| | ROSSVI | | | 9c COUNTY Balti | OF DEATH | |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 10s. STATE Md - | Baltimore | T | 10c. CITY, TO | | | | | Daire | | INSIDE CITY |
| AL DI | 10e. STREET AND NUMBER | | | | Ess | . ZIP CODE | | | 10g. CITIZEN | OF WHAT | YES 2 NO |
| UNER | 334 George 11. MARITAL STATUS | 12 WAS DECEDENT EVER | IN U.S. ARME | ED | | 212 | NIC ORIGIN? (S | | | SA RACE — AI Black, Whi | merican Indian, |
| BY | 1 Never Married 2 Married 3 Vidowed 4 Divorced | FORCES? 1 YES | | | 1 🗆 YES | ecify Cuban, Mexica 2 NO Specif | y: | | | Specify: | Nhite |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. DECE (Give life. D | EDENT'S USUA So kind of work d So NOT use retir HOUSE | NL OCCUPATION OF THE PROPERTY | st of working | 16b. KIN | D OF BUSI | NESS/INDUST | RY | |
| COM | 17. FATHER'S NAME (First, Middle, Lest) George Caha | ayla | | | | 18. MOTHER'S NA | | e Maiden S | | | |
| TO BE | 190. INFORMANT'S NAME (Type/Print) Otto Gilsing | - ger | 19b. (| | | nd Number or Rural | | | | | 21 |
| | 20a, METHOD OF DISPOSITION 20a, METHOD OF DISPOS | noval from State | OA K | F DISPOSITION | (Name of cer | tery | | | ATION — CHY Ltimo | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | censee | Hor | ne | 22. NAME A | ND ADDRESS OF FA | | Home: | 300MA | ceAv | 7e.21221 |
| | OR DARK I Enter the disease | | | | | | | | | | |
| | shock, or heat failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | complications that cause on List only one cause on Stroke | each line. | | nter the mo | de of dying, suc | h as cardiac | or respire | etory arrest | | Approximate Interval Between Onset and Death |
| NO | shock, or healt/failure. IMMEDIATE CAUSE (Final disease or condition | Stroke DUE TO (OR AS | each line. | JENCE OF): | nter the mo | de of dylng, suc | h as cardiac | or respire | etory arrest | | Interval Between |
| FICATION | shock, or heaft failure. IMMEDIATE CAUSE (Final disesse or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury | Stroke DUE TO (OR AS DUE TO (OR AS | S A CONSEQU | JENCE OF): | nter the mo | de of dying, suc | th as cardiac | or respire | etory arrest | | Interval Between |
| CERTIFICATION | shock, or heat failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | Stroke DUE TO (OR AS | S A CONSEQU | JENCE OF): | nter the mo | de of dying, suc | h as cardlac | or respire | etory arrest | | Interval Between |
| MEDICAL CERTIFICATION | shock, or heaft failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentisity list conditions, if sny, leading to immediats cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | Stroke Stroke DUE TO (OR AS DUE TO (OR AS C. OUE TO (OR AS d. OUE TO death | S A CONSEQUES A CONSEQUES A CONSEQUES | JENCE OF): JENCE OF): | | | Part I. 24 | a. WAS AN A PERFORI | WTOPSY WED? | 24b. WER AMAIN COM | Interval Between |
| MEDICAL | shock, or healt stallure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition Hypertens Diabetes 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | Stroke Stroke DUE TO (OR AS DUE TO (OR AS C. OUE TO (OR AS d. OUE TO death | S A CONSEQUES A CONSEQUES A CONSEQUES | JENCE OF): JENCE OF): suiting in th | e underlyln 26. Pi | | Part I. 246 | a. WAS AN A PERFORB | WTOPSY WED? | 24b. WER AMAIN COM | Interval Between Onset and Death RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH? |
| MEDICAL | shock, or heaft failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition Hypertens Diabetes. | Stroke Stroke DUE TO (OR AS DUE TO (OR AS OUE TO (OR AS DUE TO (OR AS | each line. S A CONSEQU S A CONSEQU D but not res | JENCE OF): JENCE OF): JENCE OF): suiting in the open of the ope | e underlyln 26. Pi HER: Nursing Hon | g cause given in | Part I. 244 1 [heck only one) 8 □ Other (Sc | a. WAS AN A PERFORA | WTOPSY WED? | 24b. WER AWAII COM OF C | Interval Between Onset and Death RE AUTOPSY FINDINGS ILABLE PRIOR TO APLETION OF CAUSE DEATH? |
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| ED BY PHYSICIAN: MEDICAL | shock, or heaft ftailure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition Hypertens Diabetes 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 WO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 29 Accident 1 Could not be detarmined | Stroke Stroke DUE TO (OR AS DUE TO (OR AS C. OUE TO (OR AS d. HOSPITAL: 11 Inpatient 2 ER/Ou 28e. DATE OF INJURY (Morth, Day, Year) | S A CONSEQUENT OF THE STATE OF | JENCE OF): JENCE OF): JENCE OF): Suiting in the DOA 4 - 28b. TIME OF INJURY Doe, farm, street the occurred at | e underlyin 26. Pi HER: Nursing Hon 28c. IN. WC M 1 t, factory, office | g cause given in LACE OF DEATH (C) 10 5 Residence 10 NO 12 NO 13 e and place, and du | Part I. 244 1 [beck only one) 8 Other (Sc 28d. DESCRI 28f. LOCATIC City or R | a. WAS AN A PERFORA PERFORA VES 2 Secify) BE HOW IN ON (Street er own, State) | NUTOPSY MED? NO JURY OCCUR NO Number or in | 24b. WER AMAP COM OF E 1 | RE AUTOPSY FINDINGS ILABLE PRIOR TO PAPLETION OF CAUSE DEATH? J YES 2 NO |
| BY PHYSICIAN: MEDICAL | shock, or heaft ftailure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition Hypertens Diabetes 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 WO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 29 Accident 1 Could not be detarmined | Stroke Stroke DUE TO (OR AS DUE T | S A CONSEQUES A CO | JENCE OF): JENCE OF): JENCE OF): Suiting in the property of the course of the cours | 26. Pl HER: Nursing Hon 28c. IN. WC M 1 the time, date my opinion, c | g cause given in LACE OF DEATH (C) 10 5 Residence 10 NO 12 NO 13 e and place, and du | Part I. 244 1 [Deck only one) 8 Other (Sp. 28d. DESCRI 28f. LOCATIC City or R a to the cause(a time, data and | a. WAS AN A PERFORA PERFORA VES 2 Secify) BE HOW IN ON (Street er own, State) | JURY OCCUR | 24b. WER AMAI COM OF E 1 | RE AUTOPSY FINDINGS ILABLE PRIOR TO PAPLETION OF CAUSE DEATH? J YES 2 NO |

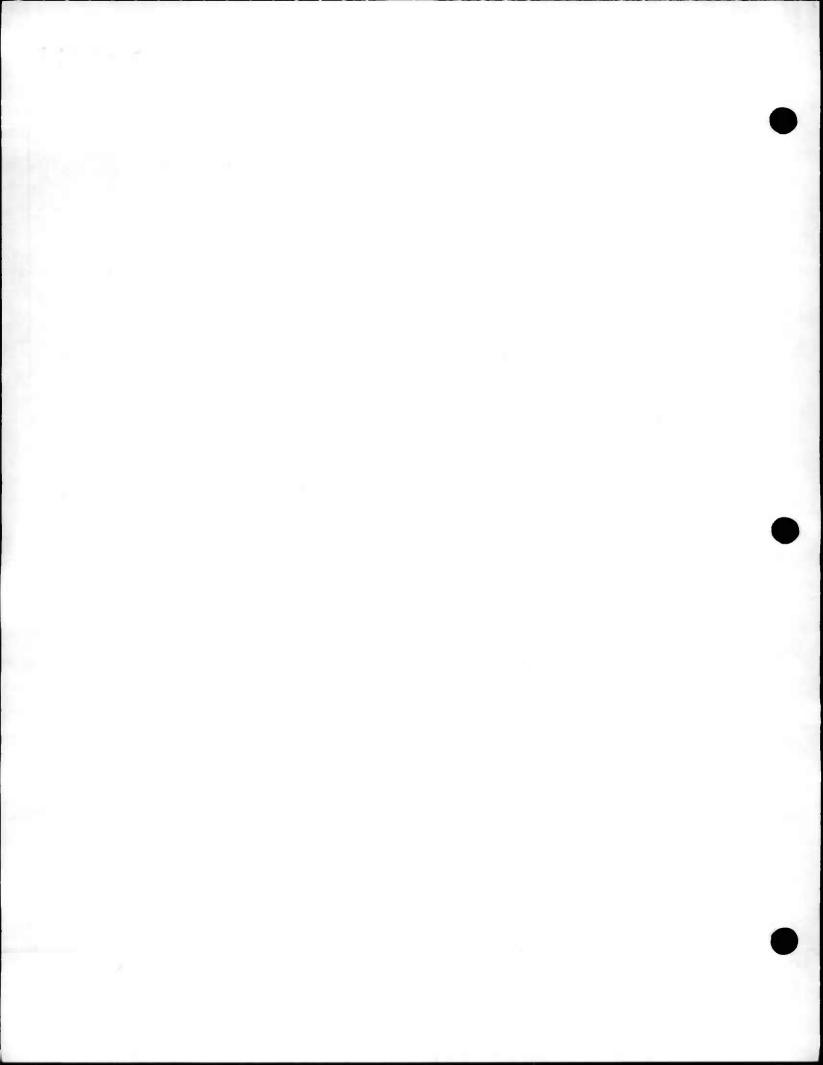
DHMH-16 Rev 1/89



permit. Pages 1, 2, 3 should

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed withinours after death. Page 6 may be retained by the hospital or attending the FUNERAL DIRECTION. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mantal Hygiene prior to burial. cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEPARTI CERTIFIC | | | HYGIEN REG. NO. | E | | |
|-----------------------|--|---|---|--|--|-------------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DATE OF DEATH | Y YEA | 3. TIME OF DEATH | |
| | | Henrietta | M. GREC | GLOIT | | cember 8 | | 12:30 A M | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | | F UNDER 1 YEAR | IF UNDER 24 HRS. 7. 1 | DATE OF BIRTH (Month, Day, Year) | 8. B | IRTHPLACE (State or Foreign ountry) | |
| | 215-05-3763 9a. FACILITY NAME (If not institution, give | | 6 YRS. | ONTHS DAYS | R LOCATION OF DEATH | ept. 14, | 1914 | Pennsylvania | |
| œ | | | | Balti | | | | | |
| DIRECTOR | FRANKLIN SQUARE HOSPITAL | | | | | | Baltimo | ore County | |
| E | 10a. STATE 10b. COUNT | | | TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? | |
| | MD Balt 100. STREET AND NUMBER | imore | Bo | altimore | ZIP CODE | | I an OFFITTING | 1 YES 2 NO | |
| FUNERAL | AND DESCRIPTION OF THE PARTY OF | - 7 7 (| | 101. | 21236 | | USA | | |
| 3 | 3903 Mewswood Lan | | | 13. WAS DEC | ENDENT OF HISPANIC O | RIGIN? (Specify Yes | or No 14. F | RACE — American Indian | |
| E | 1 Never Married 2 Married | 12. WAS DECEDENT EV FORCES? 1 IF YES, GIVE WAR (| | If yes, spe | city Cuban, Mexican, Pu 2 NO Specify: | | | Black, White, etc. | |
| ВУ | 3 X Widowed 4 Divorced | | | " | | | | White | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grad | | 16a. DECEDENT'S US (Give kind of wor | BUAL OCCUPATION to done during moderate.) | DN st of working | 16b. KIND OF BU | SINESS/INDUSTI | RY | |
| Ä | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | |
| ME | 12 - | | Housewit | re | 18. MOTHER'S NAME (| | home | | |
| | | | | | Ellen Vai | | | | |
| BE | Chester Martin 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILING A | DDRESS (Street a | nd Number or Rural Route | | | 6) | |
| 2 | Judith Dixon | | | | t. Balto., | There is an | | • | |
| | 20a, METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Ref | | 20b. PLACE OF DISPOSIT | | | | CATION City | or Town, Stata | |
| | 1 LX Burial 2 L Cremation 3 L Rar 4 Donation 5 Dother (Specify) | noval from Stata | Moreland N | Memoria: | 1 Cemetery | Ва | ltimore | , MD | |
| | 21, SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home | | | | | |
| - 5 | Mohn 6 | Jalan | A | | | | Balto. | , MD. 21204 | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Onset and Deat | | | | | | | | |
| PHYSICIAN: MEDICAL CE | PART II. Other eignificant condition | one contributing to de | | the underlyin | g cause given in Par | t i. 24a. WAS AP PERFO 1 PES | RMED? | 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PI | LACE OF DEATH (Check | only one) | | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpetient 2 EF | | OTHER: U Nursing Hom | ne 5 Residence 8 | Other (Specify) | | | |
| | 27. MANNER OF DEATH 1 Neturel 5 Pending Investigation | 28s. DATE OF INJ (Month, Day,) | | RY WC | URY AT 28 PRK? YES 2 NO | d. DESCRIBE HOW | INJURY OCCURE | ED | |
| red BY | 2 ^c Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF IN | IJURY — At home, farm, str (Specify) | | | | eet and Number or Rural Route Number, (ate) | | |
| COMPLET | TOTAL OTHY | | knowledga, death occurred | | | | | suse(a) end manner as stated. | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFI | Dard | Bluch | almo | 29c. LICENSE NUMBER | DP | | GNED (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON W | | | , | Dolle M | | | | |
| | Dr. David B. Peic | 32. REGISTRAR'S | SIGNATURE SQ | · Dr · | DdItu., ML | , | | | |



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| 3 PH | th w | Sark |
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| TEN | TOR | 90 |
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The Jaw requires that the death certificate be executed within an nouns after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach has find within 72 hours after death with the State Deut, of Health and Mental Mylene prior to burial, cremation, or removal. | The market is taken 20 is marked or flam 22 shows any fairmy or other fraumatic event the medical avainings must be notified at once |
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| 2 | 22 | 3 |

1990

Lulia Tairdson-Randale

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | ND / DEPARTM | ENT OF H | ALTH AND N | MENTAL | HYGIENE REG. NO. | 9 (|) | 34016 |
|--------------------|--|---|---|---------------------------|--------------------------------------|----------------------|------------------------------------|---------------|-------------------|--|
| | t. DECEDENT'S NAME (First, Middle, Last) JOHN W | | ET | | | MONTH | DAY | 0 9 | EAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 219-01-3241 90. FACILITY NAME (If not institution, give | 1 □ 1 2 □ F 69 | YRS. MON | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 9-2 | DE BIRTH Day, Year) | | Country) | MD |
| HO! | 1519 MANCHES | | 90. | JOP | PA , N | | | 9c. COUNTY | OF DE | ATH |
| L DIRECTOR | 10a. STATE 10b. COUNT | | | PPA, | | | | 40 - 01777 | | 10d, INSIDE CITY LIMITS? 1 YES 2/\(_\)(NO |
| UNEHAL | 1519 MANCHE | STER RD. | S ARMED | | 21085 | | ? (Specify Vee | l | JSA | |
| 1 1 | t Never Married 2 Merried 3 Wildowed 4 Divorced | | 2 NO ES | If yee, spe | cify Cuben, Mexican 2 (NO Specify | , Puerto R | | | Black, Specify | American Indian, White, etc. BLACK |
| COMPLEIED | 16. DECEDENT'S EDI (Specily only highest grad Elementary/Secondary (0-12) 9th Grade | UCATION to completed) College (1-4 or 5+) | (Give kind of work life. Do NOT use rel LABORER | done during mos ired.) | N t of working | 16b. | KIND OF BUS | INESS/INDUS | TRY | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) ABRAHAM HAM | LET | | -1 | 18. MOTHER'S NAM | | YAL | Surname) | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) ELLEN HAMLE | | 196. MAILING ADI | RESS (Street ar | STER R | oute Numb) J | OPPA, | MD. | 21 | 085 |
| | 20e, METHOD OF DISPOSITION t | [0 0M | HACE OF DISPOSITION (ther place) | BAPT. | CH. CE | | | PA, M | | rn, State |
| | * (alvin L | · Williams | | WM.C | . MARCH | ł F. | | | | ORTH AVE. |
| | 23. PART I: Effer the diseases, or ehock, or heert failure IMMEDIATE CAUSE (Final disease or condition resulting in desth) | a. DUE TO (OR AS A C | h lina. | | | | llec or reepi | ratory arrest | • | Approximate interval Between Onset and Death |
| ALION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING | bDUE TO (OR AS A C | | • | | | | | ·- | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | OUE TO (OR AS A C | ONSEQUENCE OF): | | | | | | | |
| CAL | PART II. Other algnificant condition | ne contributing to death but | not resulting in t | ha underlying | cause given in | Part I. | 24a. WAS AN PERFOR | MED? | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL | 1 | | 26. PL | ACE OF DEATH (Che | eck only on | e) | | | T L YES 2 L NO |
| YSIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpat | lent 3 DOA 4 | | 5 🗆 Residence | - | | | | |
| Y PH | 27. MANNER OF DEATH t \(\bigcap \): Natural 5 \(\bigcap \) Pending 2 \(\bigcap \) Accident investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | WO | JRY AT RK? ES 2 NO | 28d. DEŞ | CRIBE HOW II | NJURY OCCUP | ED | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Specify | – At home, farm, stree () | it, factory, office | | 28f. LOCA City of | ATION (Street e or Town, State) | and Number or | Rural Ro | oute Number, |
| COMPLETED | enel enel | SICIAN: To the best of my knowled | | | | | | | | end manner as stated. |
| O BE C | 296. SIGNATURE AND TITLE OF CERTIFI | lunertlal, | | | D 39 | ABER 413 | ٩ | | | (Month, Day, Year) |
| | | MENTHAL M | D | _ | 71417 | S | Q H | OSPU | 7 4 | 96 |
| | 31. DATE FILED (Month, Dey, Year) | 32. REGISTRAR'S SIGNAT | TURE | | | | | | | |

DHMH-18 Rev 1/89

E40"F 16.

FOR STATE REGISTRAR

1 -

DIRECTOR

FUNERAL

BY

COMPLETED

BE

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

ED 日 COMPL

BE

2

10a. STATE

Mary1and

11. MARITAL STATUS

10e. STREET AND NUMBER

12th Grade

disease or condition_

29b. SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

resulting in death)

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filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should on, or removal. nours after death. Page 6 may be retained by the hospital or attending physician. notified at 9 must examiner medical I completely filled inal, cremation. the executed within traumatic event, attending physician and con ntal Hygiene prior to bunal, certificate be or other the death After this certificate has been signed by the atter death with the State Dept. of Health and Merital Injury, that shows any ME 23 The DR ATTENDING PHYSICIAN: marked, or TO THE HOSPITAL DR ATTENDIN TO THE FUNERAL DIRECTOR: At be filed within 72 hours after de IMPORTANT: It Item 28 is in 00

34017 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 90 **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY YEAR 12 9 1990 Miriam M. Hunt 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS 1 M 2 X F 213 38 9284 82 YRS. 3-6-1908 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 8375 Penn Drive Pasadena Anne Arundel RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 TYES 2 NO Anne Arundel Pasadena 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 8375 Penn Drive 21122 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2X NO Specify: 1 Never Married 2 Marr Specify. 3 X Widowed 4 Divorced White 16a, DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Sales Clerk Bakery 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) J. Frank Mattingly Laura R. Lawson 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1988 Goose Neck Road Marcia H. Conrad Pasadena, Maryland 21122 20e. METHOD OF DISPOSITION
1 Burlal 2 Cremation 3 R 20b. PLACE OF DISPOSITION (Name of cametery, crematory or 20c. LOCATION — City or Town, State Metro Crematory, Inc. Baltimore, Maryland 4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. Cec 4001 Ritchie Hwy. Baltimore, Md. 21225 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximate** ahock, or heart failure. List only one cause on each line. interval Between **Onset end Death** IMMEDIATE CAUSE (Final Sequentially list conditions, if any, leading to immediate DUE TO JOR AS A CONSEC CE OF cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): NGS

| that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE | QUENCE OF): | | | | |
|---|--|-----------------------------|------------------------------------|--------------|--|--|
| PART II. Other significant condition Conceptur Palm | e front of | hysim | 4 | Part I. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 DNO | 24b. WERE AUTOPSY FINDI AMAILABLE PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ОТНЕ | 28. PLACE OF DEATH (C | heck only or | ne) | |
| 1 TES 2 NO | 1 Inpetient 2 ER/Outpetient 3 | | reing Home 5 Residence | 6 🗆 Othe | er (Specify) | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c, INJURY AT WORK? 1 YES 2 NO | 28d. DE | SCRIBE HOW INJURY OCCUR | ED |
| 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, street, fa | ctory, office | | CATION (Street and Number or or Town, State) | Rural Route Number, |
| (Check only | ICIAN: To the best of my knowledge, de SR: On the basis of exemination and/or | | Annual or the contract of the last | | | |

29c. LICENSE NUMBER



32. REGISTRAR'S SIGNATURE

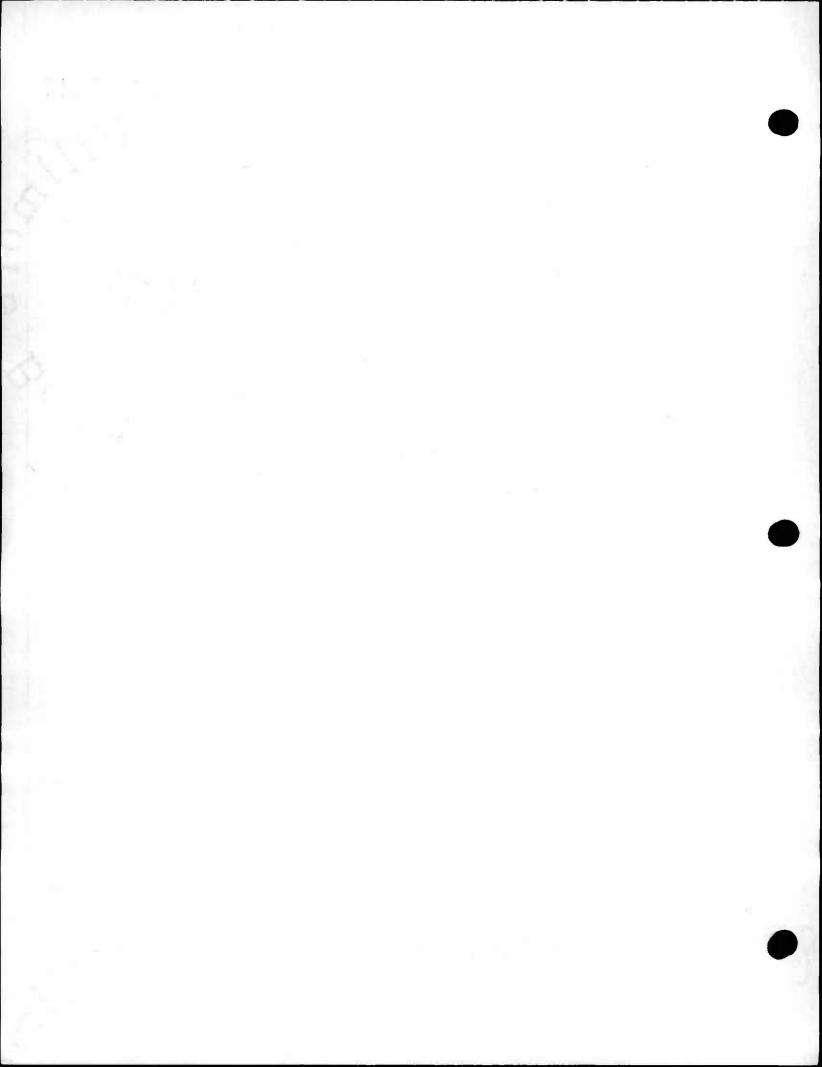
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

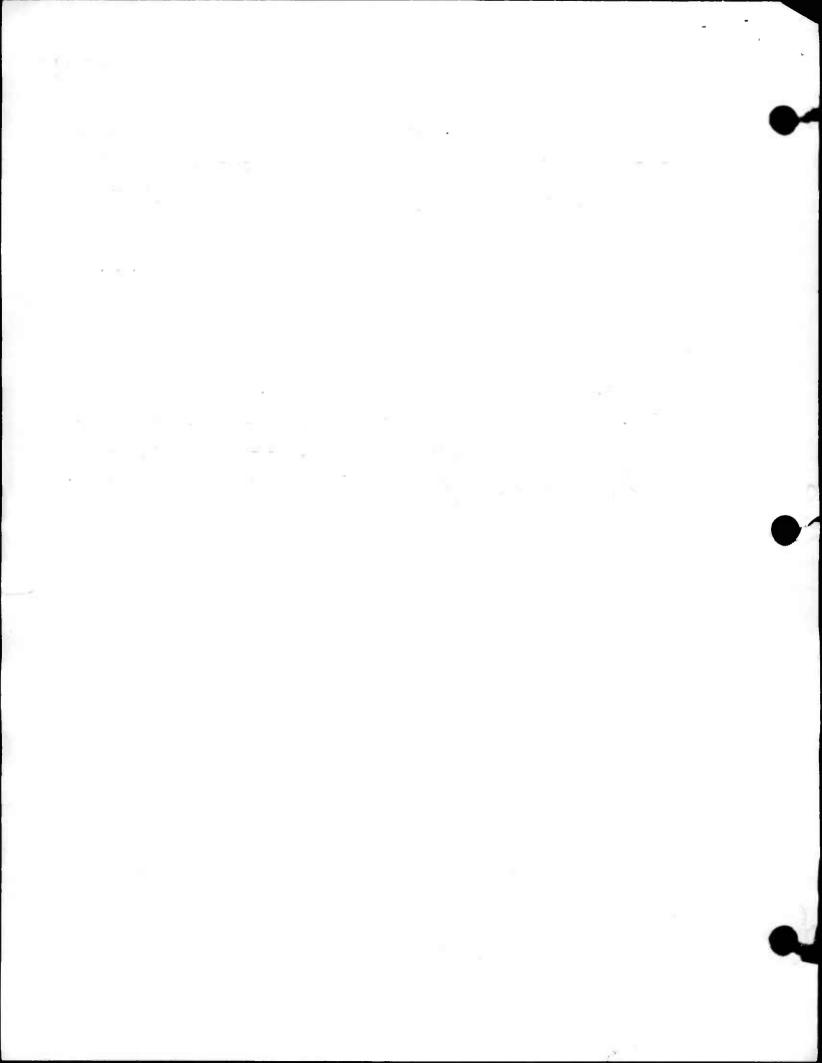


| in 24 mours after death. Page 6 may be retained by the hosp | ely filled in by the funeral director, page 5 should be detached nation, or removal. | , the medical examiner must be notified at once. | |
|---|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he filed within 72 hours after death with the State Dent, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
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| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|--|-----------------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / CE | | OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | | |
|--|--|--|--|--|---|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Midello I and | WILLIAM C. H | - | | 2. DATE OF DEATH MONTH DAY | Syear 3. Time of Death 90 2154 M | | | |
| | 212-26-0931 | SEX 6. AGE (In yrs. last | YRS. MONTHS | DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 6 6-14-1930 | 6. BIRTHPLACE (State or Foreign Country) MARYLAND | | | |
| TOR | 99. FAÇILITY NAME (If not institution, give stree NORTH ARUNDEL GENE AESIDENCE OF DECEDENT | |) 8b. CITY | GLEN BURNIE | i | ANNE ARUNDEL | | | |
| FUNERAL DIRECTOR | | TIMORE | 10c. CITY, TOWN | DUNDALK | | 10d. INSIDE CITY LIMITS? 1 YES XX NO | | | |
| VERAL | 10s. STREET AND NUMBER 7217 DUNGLEN COURT | | | | 222 | 0g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| B | 11. MARITAL STATUS 1 | 2. WAS DECEDENT EVER IN U.S. AR FORCES? 1 X YES 2 □ N IF YES, GIVE WAR OR DATES WW TT | 10 | WAS DECENDENT OF HISPAN If yes, specify, Cuben, Mexica 1 YES 2 NO Specify | n, Puerto Ricen, atc.) | No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade co Elementary/Secondary (0-12) 7TH GRADE | mpleted) (Gi | CEDENT'S USUAL O the kind of work done Do NOT use retired.) TRUCK 1 | during most of working | 186. KIND OF BUSINI | ESS/INDUSTRY & KIRKWOOD | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) CHARLES H. HEIDE | <u> </u> | | 100 | Me (First, Middle, Melden Sur M. BUTCHER | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) VIOLET M. HEIDEL | | 7217 DUNG | s (Street and Number or Rural I GLEN COURT | BALTIMORE, | MARYLAND 21222 | | | |
| | 20a. METHOD OF DISPOSITION 1A Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | GARDE | NS OF FA | ame of cemetery, cremetory or NITH CEM. 12- | -8-90 BALTI | TION — City or Town, Slate MORE, MARYLAND | | | |
| | 21. BIONATURE OF YUMERAL SERVICE LICEN | tish | DU 79 | NAME AND ADDRESS OF FA IDA-RUCK FUNT 122 WISE AVEN | ERAL HOME OF NUE DUNDALK | DUNDALK, INC. | | | |
| | 23. PART I. Enter the diseases, or complicatione that cause the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DIA DE TO 6 | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | | | | | | | | |
| CAL | PART II. Other algnificant conditione | contributing to death but not r | resulting in the u | nderlying cause given in | Part I. 24a. WAS AN AU PERFORMI 1 U YES 2 | ED? AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | |
| HYSIC | | OSPITAL: Inpatient 2 FR/Outpatient 3 28e. DATE OF INJURY | 28b. TIME OF | rsing Home 5 - Residence | 8 Other (Specify) | URY OCCURED | | | |
| B | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | (Month, Day, Year) 28e. PLACE OF INJURY — At ho building, etc. (Specify) | INJURY M ome, farm, streel, fac | WORK? 1 YES 2 NO | | | | | |
| COMPLETED | 290. CERTIFIER (Check only 1 CERTIFYING PHYSICIA | AN: To the best of my knowledge, de | | | | or as stated. due to the cause(s) and manner as stated. | | | |
| TO BE CO | 29b. SIGNATURE AND TITLE OF CERTIFIER | Jan, mp I |)ери: | Fy DO | MBER 2 | 29d. DATE SIGNED (Month, Day, Year) 13/5/90 | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM PLONES, MD 695 AMERICA CT. 21 31. DATE FILED (April On Nov.) | | | | | | | | | |

DEC 1 1 1990



| TO BE COME | TO BE COMBLETED BY BUYERCIAN: MEDICAL CERTIFICATION |
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| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| ne funeral director, page 5 should be detached | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached |
| r death. Page 6 may be retained by the hosp | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Hours after death. Page 6 may be retained by the hosp |
| | |

8 Could not be

SIGNATURE AND TITLE OF CERTIFIER

| | | | | | | | | | | 0 | 040.0 |
|---------------|--|---------------------------|---------------------|---|-----------------|----------------------------|-------------|-------------------------------|-------------------------------|--------------|---|
| | 1 - FOR STATE REGISTRAR | STATE OF N | (NARYLAND | | | F HEALTH | | | YGIENE EG. NO. | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | · | | | | | | 2. OATE OF O | EATH DAY | YEAR | 3. TIME OF OEATH |
| | | Charles | B. Har | risor | ı, Jr | | | 12 | | 990 | М |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. las | t birthday) | IF UNDER 1 Y | | R 24 HRS. | 7. DATE OF BI (Month, Day, | | 6. BIRT | HPLACE (State or Foreign |
| | 248-18-3181 | 1 ★ M 2 □ F | 79 | YRS. | MONTHS D | AYS HOURS | MIN. | | - 1911 | | S. C. |
| | 9e. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TO | WN OR LOCAT | ON OF DEA | тн | 9c. C0 | OUNTY OF | DEATH |
| 8 | 2317 W. Lexingt | on Stree | t | | Bal | timore | | | | | |
| 5 | | | | 20.0 | | | | | | | Turning and |
| DIRECTOR | 100. STATE 10b. COUNTY | | | | timor | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| A | 10e. STREET AND NUMBER | 6.1 | | | | 10f. ZIP COC | | | | | WHAT COUNTRY? |
| E | 2317 W. Lexingt | on Stree | t | | | | 21223 | | l 0 | S A | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. WE | RMED | | | | | ecify Yea or No- | - 14. RAC | CE — American Indian, ck, White, atc. |
| BY | 1 Never Merried 2 X Merried 3 Widowed 4 Divorced | IF YES, GIVE V | | 110 | 1 [| s, specify Cub YES 2 NO | Specify: | , ruento micen, | attaj | Spe | |
| | | <u> </u> | | | | | | | | 1 | DIACK |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade | completed) | (6 | | work done duri | PATION ng most of work | Ing | 16b. KINC | OF BUSINESS/ | INDUSTRY | |
| ا ڐ ا | Elementary/Secondary (0-12) | College (1-4 or 5 | -) // | . DO NOT U | 30 100100.7 | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 10.00 | NED'S NAM | E /Elmt Alidella | Maiden Sumame | a). | |
| | Charles B. Harr | rision. S | r | | | | | Praylo | | P) | |
| B | 19e. INFORMANT'S NAME (Type/Print) | 131011, 3 | | 6. MAII IN | Annese /c | | | | ity or Town, State, | Zio Codel | |
| 임 | Betty B. Harri | ison | " | | | | | | | | ld 21223 |
| | | | 20h PLACE | | | of cemetery, cre | | 1 000 0 | 20c. LOCATION | | |
| | 20a METHOO OF DISPOSITION 1\(\bigc\) Suriel 2 \(\bigc\) Cremetion 3 \(\bigc\) Rem 4 \(\bigc\) Donetion 5 \(\bigc\) Other (Specify) | oval from Stete | other p | (ace) | | tar Ce | • | | Catons | - | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | NCS | | ME ANO ADORI | | | Cucon | 3 4 1 1 1 | C, Mu |
| | ► "Z/200.0 | 20 | 0 | | | March | F/H W | est | | | |
| | | some) | mp | | | 4300 | | | | | |
| | 23. PART I. Enter the diseases, or shock, or heart failure. | | | | not enter th | e mode of dy | ing, such | aa cardiec | or reepiretory | errest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel | a | 1 | | | 1 | 1 | 1 | | | Onset and Death |
| | disease or condition recuiting in daeth) | · Acu | e | Ce | re | mal | | en | OVY | 0.00 | In trut |
| | | DUE TO | (OR AS A CONSE | OUENCE | OF): | 0 | 0 | _ | ovyh | / | 171 |
| Z | Sequentially list conditions, | cen | ora | | tribe | 100 | 201 | evo. | SCS | | 15 y 15. |
| Ĕ | If any, leading to immediate cause. Enter UNDERLYING | DUE 10 | (OR AS A CONSE | OUENCE |)F): | 10/10/ | 2 10 | 25 | 01 1 | | 1 -100 |
| 15 | CAUSE (Diseese or Injury | c. Due To | MA A CONSE | CL [| 17 | yju | u je | usi | 001 | | 6 WY |
| Ē | that initieted events reaulting in death) LAST | DA | enn | | 200 | | | | | | 7-14/201 |
| CERTIFICATION | | d | -encode | -00 | ruce | | | | | | - inigs |
| | PART II. Other significant condition | na contributing to | death but not | reaulting | In the unde | rlying ceuea | given in F | Part I. 24a | . WAS AN AUTOP: PERFORMED? | SY 2 | Ib. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | | | | | | | | 15 | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| ᇦ | | | | | | | | | | 1 | 1 YES 2 NO |
| | | | | | | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 26. PLACE OF | OEATH (Che | ck only one) | | | |
| Sic | 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | Home 5 🗆 F | Reeldence (| 6 Other (Spi | ecify) | | |
| ¥ | 27. MANNER OF OEATH | 28a. DATE Of (Month, I | | 28b. TII | ME OF 28 | c. INJURY AT WORK? | | 28d. DESCRIE | BE HOW INJURY | OCCURED | |
| ВУ Р | 1 Natural 5 A Pending 2 Accident Investigation | (month, a | ,, ,,,,, | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | 1 YES 2 | □ NO | | | | |
| 8 | 3 Suicide 8 Could not be | 28a. PLACE (| OF INJURY — At h | ome, farm, | atreet, factory | , office | | 28f. LOCATIO | N (Street and Nurr | nber or Rura | l Route Number, |

1 Territying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuas(e) end menner as ateted.

29c LICENSE NUMBER



TO BE COMPLETED

4 Homicide

29e. CERTIFIER (Check only one)

29d. DATE SIGNED (Month, Day, Year)

▶ 12 - 10-9

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for

31. DATE FILED (Month, Day, Ye

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| 0 | Q | R: A |
| <u>s</u> | ATTE | S afte |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | S, | DIR |
| | (OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🗻 Jours after death. Page 6 may be retained by the hospit | UNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached rithin 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
| | OSP | UNE |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG. NO 2. DATE OF DEATH 3. TIME OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 12-6-90 Hoffman 5:43AM Joe1 J. A SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR ___ IF UNDER 24 HRS 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 5. SEX MONTHS DAYS HOURS MIN 1 X M 2 F 12 218-76-2453 18 14 MARYLAND Se. FACILITY NAME (If not institution, give street end number, 95 CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 1017 W. 36th Street-roof Baltimore City RESIDENCE OF DECEDENT 10b COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 10e. STATE MARYLAND BALTIMORE 1 X YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e STREET AND NUMBER 10f. ZIP CODE 1017 WEST 36TH STREET 21211 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 THOO IF YES, GIVE WAR OR DATES 14. RACE — American Indien, Black, White, etc. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

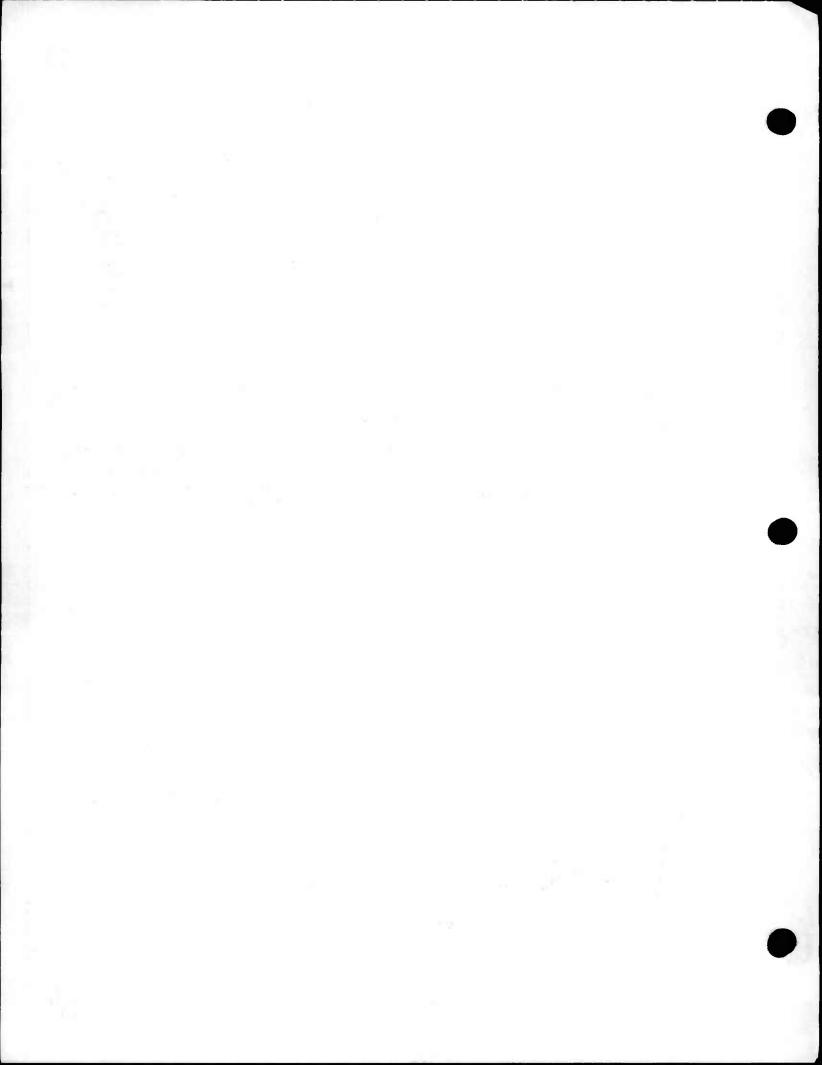
1 YES 2 XNO Specify: 1 Never Married 2 Merried Specify: BY 3 Widowed 4 Divorced WHITE 16a. DECEDENT'S USUAL OCCUPATION COMPLETED 15. DECEDENT'S EDUCATION 16h KING OF BUSINESS/INQUSTRY (Specify only highest grade comple Elementary/Secondary (0-12) College (1-4 or 5+) 8TH STUDENT 18. MOTHER'S NAME (First, Middle, Maiden Surname) 17 FATHER'S NAME (First Middle Last) to MARTIN L. HOFFMAN, SR. BETTY ALMOND notified 19. INFORMANT'S NAME (Type/Print) 19b. MAILING AGORESS (Street and Number or Rural Routs Number, City or Town, State, Zip Code) 2 BETTY HOFFMAN 1017 WEST 36TH STREET, BALTO., MD. 21211 pe 20e. METHOD OF DISPOSITION
1 Durial 2 Cremation 3 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 3 🗆 Removal from State must CEDAR HILL CEMETERY BROOKLYN PARK, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner 22. NAME AND ADDRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME leci Klun 3615-19 CHESTNUT AVENUE, BALTO., MD. 2121 medical 23. PART I. Enter the diseases, or complications they daused the death. Do not enter the mode of dying, such as cerdiac or respiratory erreat, shock, or haert feilure. List only one ceuse on each line. Approximete Interval Between **Onset and Death** IMMEDIATE CAUSE (Final 事 disease or condition Hanging event. resulting in death) DUE TO (OR AS A CONSEQUENCE OF) traumatic CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury other 1 DUE TO (OR AS A CONSEQUENCE OF) that initiated event resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO COMPLETION DF CAUSE shows any XIX YES 2 | NO XXXYES 2 NO PHYSICIAN: Dept. 26. PLACE OF OEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL After this certificate his death with the State D marked, or Item 3 Item OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA XXXES 2 NO raing Home 5XX Besidence XXXX ther (Specify) Roof 4 🗆 Nu 28c. INJURY AT WORK? 28a. DATE OF INJURY 26b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 27. MANNER OF DEATH 90 5:30AM 1 WORK? FOUND: 12-6-Subject hanged self 1 Netural 5 Pending BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home-roof 281. LOCATION (Street and Number or Aural Route Number, 1077 W. Stag 6th Street, Baltimore, MD XXXSuicide 6 Could not be determined DIRECTOR: A Lours after of Item 28 Is 99 ETED. 4 Homicide 29e. CERTIFIER (Check only one)

1 CERTIFIER (Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner se attated.

29 CERTIFIER (Check only one)

29 AMERICAL EXAMINED: On the bast of sympletic and place and due to the cause(e) and COMPL TO THE HOSPITAL
TO THE FUNERAL I
Be filed within 72 h
IMPORTANT: If I MEDICAL EXAMINER: On the base of examination end/or investigation, in my opinion, death occurred at the Ilma, date end place, end due to the ceuse(e) end manner se stated. 296. SENATURE AND TITLE 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month. Day, Year) BE 12-6-90 OCME 2 S OF PERSON W O COMPLETED CAUSE OF DEATH (FTEM 27) (Type, Print) 111 Penn Street, Baltimore, MD 21201 ANN M. DIXON MD

DHMH-16 Rev 1/89



3. TIME OF DEATH 2:05 P

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| 'n | Annual of Attendant DUVCIOIAN. The law consists the tent death certificate he executed within |
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| , P.O. BOX 13146, | OV6 |
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| DIVISION OF VITAL RECORDS, | 4 |
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7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 6. AGE (In rs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Allegany County 218-48-9999 88 1 - M 2 K F 10-14-02 Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF WEATH Bon Secours Hospital Battimore. DIRECTOR Baltimore City RESIDENCE OF DECEDENT 10b. COUNT 10c, CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY Westernport 1X YES 2 NO Allegany permit. L Md FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 27-rours after death. Page 6 may be retained by the hospital or attending physician. officed in by the funeral director, page 5 should be detached for use as the burial-transit to or removal. 21562 US 114 Wood St 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yee, specify Cuben, Maxicen, Puerto Rican, etc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EYER IN U.S. ABMED FORCES? 1 YES 2 4NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried Specify: White BY 3 Widowed 4 ☐ Olvorced 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp (Give kind of work done life. Do NOT use retired.) Ы Elementary/Secondary (0-12) College (1-4 or 5+) Unknown COMPL Housewife Domestic 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) at Gideon Reitz BE Daisv Wilt 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2018 Ramsey St. Baltimore, Md. 21223 Beatrice Kert pe 20a. METHOO OF USPOSITION 1 XI Burlel 2 Commention 20c. LOCATION -- City or Town, State PLACE OF DISPOSITION (Name of cemetery, cremetory or must t 1 X Burlel 2 ... Cremation 3 4 ... Donation ... Other See Philos Cemetery Westernport, Md. examiner 22 NAME AND ADDRESS OF FACILITY
Boal-Warnick Funeral Home 111 Church St. Westernport, Md. medicai 23. PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ahock, or heart failura. List only one cause on each line. Interval Batween Onset and Daath cremation, or IMMEDIATE CAUSE (Final the disease or condition resulting in death) attending physician and completely in real Hygiene prior to burial, cremation event, DUE TO (OR AS A CONSEQUENCE OF): item 23 shows any injury, or other traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, laading to immediata cause. Entar UNDERLYING een signed by the attending physiciar of Health and Mental Hygiene prior CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initisted events resulting in death) LAST neitions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? TYES 2 | NO 1 YES 2 NO this certificate has been with the State Dept. of h PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO ng Home 5 - Reeldence 6 - Other (Specify) 4 🗌 Nursi 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 28 is marked, 1 Natural м 1 YES 2 NO death BY Investigati After 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 8 Could not be FUNERAL DIRECTOR: within 72 hours after u 4 Homicide MPORTANT: If Item 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the cause(s) end manner as stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and manner as stated 296, SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month Day THE H BE 9 TED CAUSE OF DEATH (ITEM) 27) (Appl DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

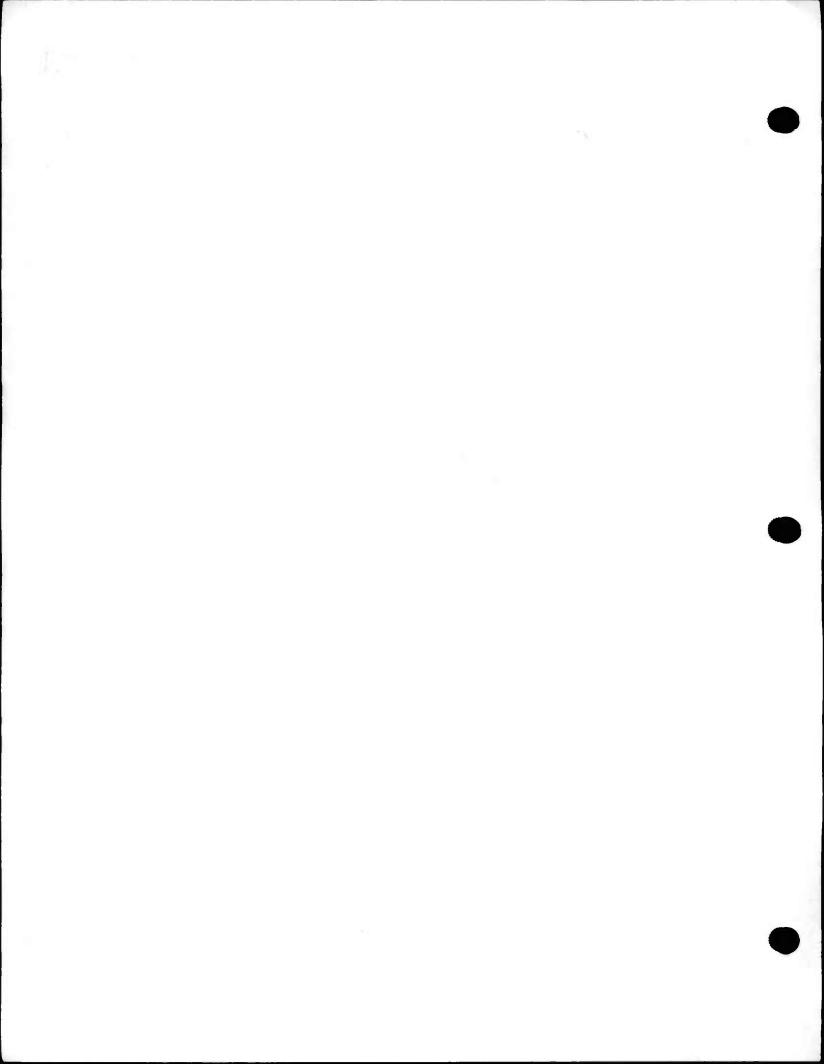
2. DATE OF DEATH

12

04

90



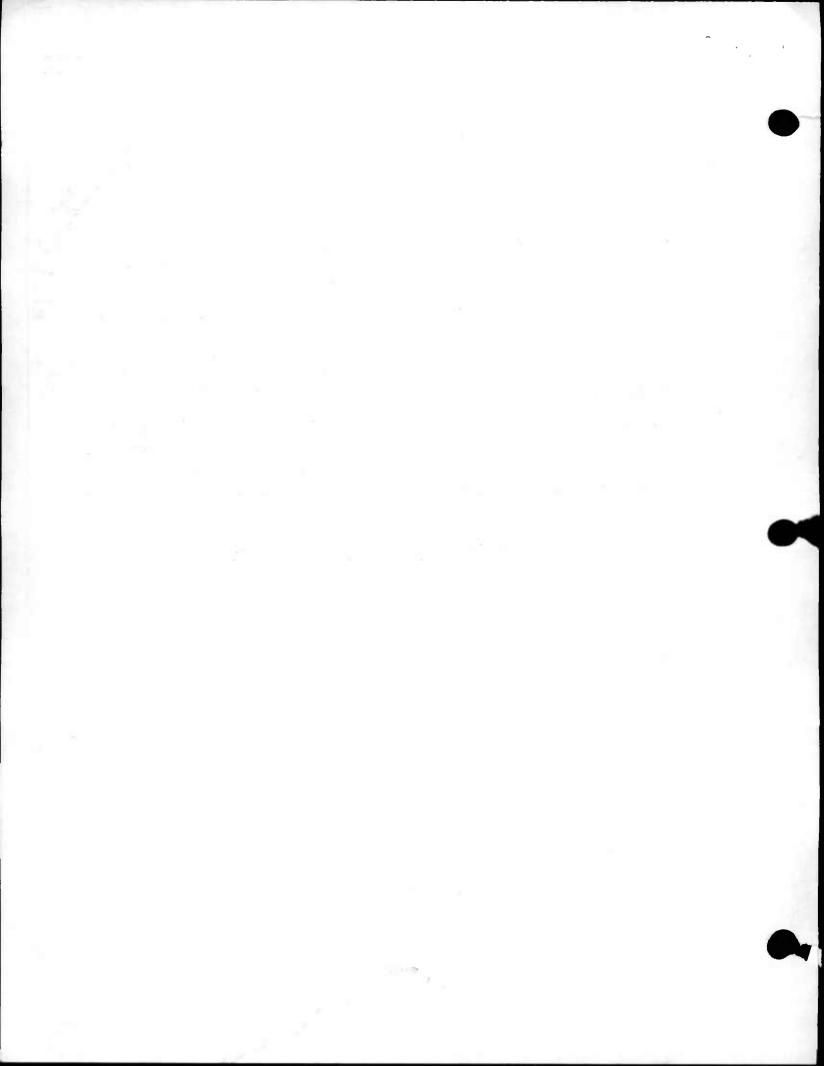


| after death. Page 6 may be retained by the hosp | by the funeral director, page 5 should be detached smoval, | traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within controls after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he stard within 72 hours after death with the State Dedt, of Health and Mental Hydlene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| FOR | STATE OF ! | MARYLAND / | DEPART | MENT OF | HEALTH AN | ID MENT | AL HYGIEN | 9 E | U : | 34022 |
|--|-------------------------|--|-----------------------------|--------------------|--|----------------------|---|------------|--------------|--|
| 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Las | | CE | RTIFIC | CATE OI | DEATH | | REG. NO. | | 7EAR 3. 1 | TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | JOHN WE | | HIGH, | SR. | | E OF BIRTH | | BIRTHPLA | 530 A CE (State or Foreign |
| 5-03-5892 | 1 M 2 F | 75 | YRS. | MONTHS DAYS | | 1.1- | 4-15 | | Maryl | |
| 9s. FACILITY NAME (If not institution, given North Arundel H | | | | Glen B | urnie | OF DEATH | | | Arun | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUR An | nv ne Arunde | 1 | | n Burn | | | | _ | | 1. INSIDE CITY LIMITS? YES 2 NO |
| 100. STREET AND NUMBER 204 Vernon Ave. | | | | | 21061 | | | U.S | | COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 A Married 3 Widowed 4 Divorced | FORCES? IF YES, GIVE | NT EVER IN U.S. ARI I X YES 2 N WAR OR DATES | MED | If yes, | ECENDENT OF H specify Cuban, M ES 2 X NO | lexican, Puer | GIN? (Specify Yes to Rican, etc.) | s or No 1 | Specify: | American Indian, hits, etc. |
| 15. DECEDENT'S E (Specify only highest on Elementary/Secondary (0-12) | College (1-4 or 5 | +) (Gi | he kind of we Do NOT use | - 17 | most of working Mechnic | | Trucki | COCITIVAS | | |
| 17. FATHER'S NAME (First, Middle, Lest) William Sam Hi | gh | | ` | | 18. MOTHER | 'S NAME (Fire | st, Middle, Maiden Westpha | | | |
| 19a. INFORMANT'S NAME (Type/Print) Elizabeth C. Hi | | | | | | | umber, City or Tow | | | |
| 20a, METHOD OF DISPOSITION 1 Disposition 3 R | | 20b. PLACE other pla | OF DISPOSI | TION (Name of | cometery, cremeto | ry or | 20c. LC | en Bur | ty or Town, | |
| 21. SIGNATURE OF FUNCTIAL, SERVICE | LICENSEE | _ Gre | n nav | 22. NAME Sin | and address gleton | of facility Funer | al Home | 2 | • | Md. 2106 |
| 23. PAY Print the diseases of shock, or heart failure immediate CAUSE (Final disease or condition resulting in death) | sDUE TO | at caused the deuse on each line | | | | | ardiac or resp | | st, | Approximate Interval Betwee Onset and Dec |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | O (OR AS A CONSE | | | | _ | | | | |
| PART II. Other significant condit | iona contributing t | o death but not | resulting i | n the underly | ing cause giv | en in Part i | | RMED? | CC | ERE AUTOPSY FINDING NALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ☐ ER/Outpatient : | | OTHER: | PLACE OF DEA | 500 W 131 | | * | | · · · · · · · · · · · · · · · · · · · |
| 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE ((Month, | | 28b. TIM | E OF 28c. | IOME 5 Resid | 28d. | DESCRIBE HOW | INJURY OCC | URED | |
| 2 Accident Investigation 3 Suicide a Could not 4 Homicide determined | 26a. PLACE buildin | OF INJURY — At hi g, etc. (Specify) | ome, farm, s | street, factory, o | ffice | | LOCATION (Street City or Town, State | | or Rural Rou | te Number, |
| (Check only | IYSICIAN: To the best | | | | | | • • | | | nd menner as stated |
| 296. SIGNATURE AND TITLE OF CERT | FIER | 7 | F | - | 29c. LICEN | SE NUMBER | +00 | 29d. DATE | SIGNED (M | fonth, Day, Year) |
| 30, NAME AND ADDRESS OF PERSON | WHO COMPLETED'C | WSE OF DEATH (ITE | EM 27) (Type, | . Print) | - | 10. | 100 | | | 1.0 |

Julia Davidson-Andelle

DEC 11 1990



| TO BE COMPLETED BY ELINER | SO DE COMOS ETED DV DUVOIOIAN. MEDIOAL CEDITICIOATION |
|--|--|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| al, | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. |
| he funeral director, page 5 should be detached for use as the burial-transit | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit |
| ir death. Page 6 may be retained by the hospital or attending physician. | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within . Loss after death. Page 6 may be retained by the hospital or attending physician. |
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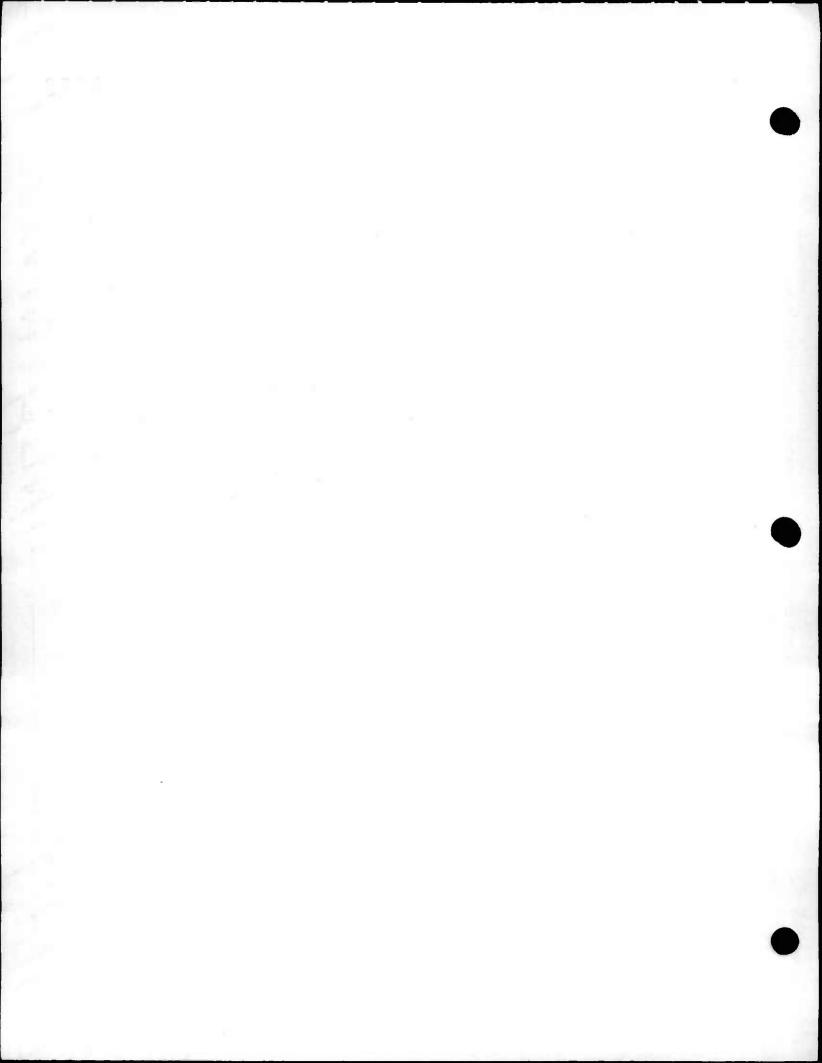
| 1. DECEDENT'S NAME (First, Middle, Last) | | OLITTI. | 10/114 | OF DEATH | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
|--|--|---|---|---|--|---------------|--|--|--|
| AD | ELE HINTON | I | | | 12 B | 90 | AR M | | |
| 4. SOCIAL SECURITY NUMBER 220-24-9176 | | (In yrs. leat birthday) 4 YRS. | MONTHS DAYS HOURS MIN. (Month, Day, Year) Coun | | | | IRTHPLACE (State or Foreign ountry) VIRGINIA | | |
| 9e. FACILITY NAME (if not institution, give st | | 1G \ | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | |
| 2609 LIBERTY H | EIGHTS (RE | es.) | BAI | TIMORE C | ITY | | | | |
| 10a, STATE 10b, COUNTY MARYLAND 10a, STREET AND NUMBER | | 10c. CIT | ry, town or Lo | CTIMORE C | TTY | 40- CITIZEN | 10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? | | |
| 2609 LIBERTY H | EIGHTS AVE | ENTIE | | 21215 | | | JSA | | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EYER I FORCES? 1 YES IF YES, GIVE WAR OR D | N U.S. ARMED | If yes | | | or No- 14, 1 | BLACK Specify: BLACK | | |
| 15. DECEDENT'S EDUC (Specify only highest grade | ATION completed) | 18a. DECEDENT'S | work done during | PATION g most of working | 16b. KIND OF BUS | INESS/INDUSTI | RY | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Ille. Do NOT u | oo retired.) | | | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) | | | 30111301 | | ME (First, Middle, Maiden | Surname) | | | |
| | | | | LUCIL | LE HARRI | S | | | |
| 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | | · · | | |
| CHARLES MCCOY | | | | ERTY HEIG | | CATION City | O., MD 212 | | |
| 20e. METHOD OF DISPOSITION 1 | oval from State | other place) | | L PARK | | | RE, MARYLAN | | |
| 23. PART I. Enter the diseases, or cahock, or heart failure. | complications that chuse | d the death. Do | 460 | 10 LIBERT | Y HEIGHT | S AVE | ERAL HOME VIIE 21207 Approximata Interval Between Onset and Deat | | |
| IMMEDIATE CAUSE (Final) disease or condition resulting in desth) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| UI . | | // 0 | 0000 | 0. | | | 9 . | | |
| Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE O | ell | lung | conce | | Zmns Syr. | | |
| If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initisted events | d | 0 0 | 1 | lung | Part I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AWALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | |
| If any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | d | but not resulting | In the under | Tying cause given in | PERFOF 1 YES 2 | MED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| If any, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 ER/Out 28e. DATE OF INJURY (Month, Dey, Year) | but not resulting | OTHER: 4 Nursing M 0 1 | 28. PLACE OF DEATH (CA Home 5 Residence c. INJURY AT WORK? | PERFOF 1 YES 2 Peck only one) 8 Other (Specify) 28d. DESCRIBE HOW if | NJURY OCCURE | AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | |
| If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINERY? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be determined determined 29s. CERTIFIER (Check only) | HOSPITAL: 1 Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Sp. | tpatient 3 DOA 28b. Till IN Y — At home, farm, scify) | OTHER: 4 Nursing ME OF JURY M 1 , street, factory, | 28. PLACE OF DEATH (CA Home 5 N Residence C. INJURY AT WORK? YES 2 NO office | PERFOF 1 YES 2 There is a second one in the se | NJURY OCCURE | AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | |

30. NAME AND ADDRESS OF THE THREE PLANTS OF THE THREE (Month, Day, Year)

NFC 11 1990 Su John's Hop King Open Ingg.
32. REGISTRAR'S SIGNATURE
a Davidson-Randelle DHMH-16 Rev 1/89

500 N. Wolfe St, Balto, MD 21205

AUSE OF DEATH (ITEM 27) (Type, Print)



TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.

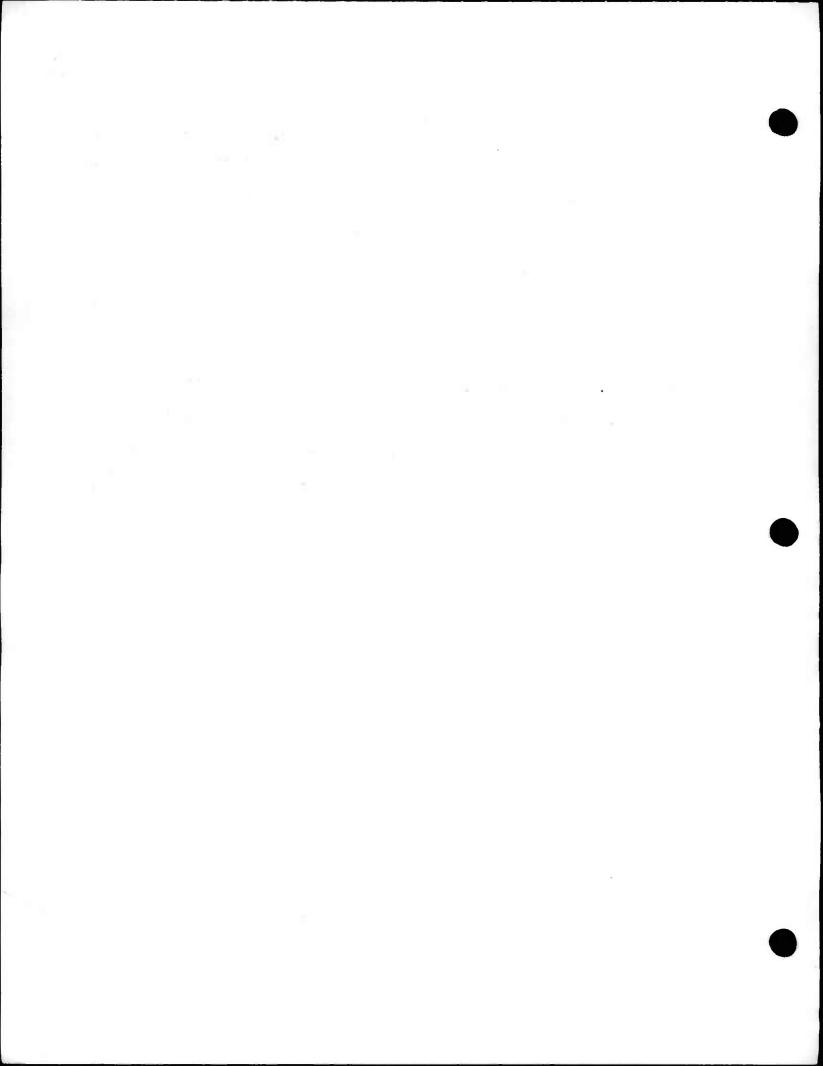
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burnal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notfilled at once. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY FINERAL

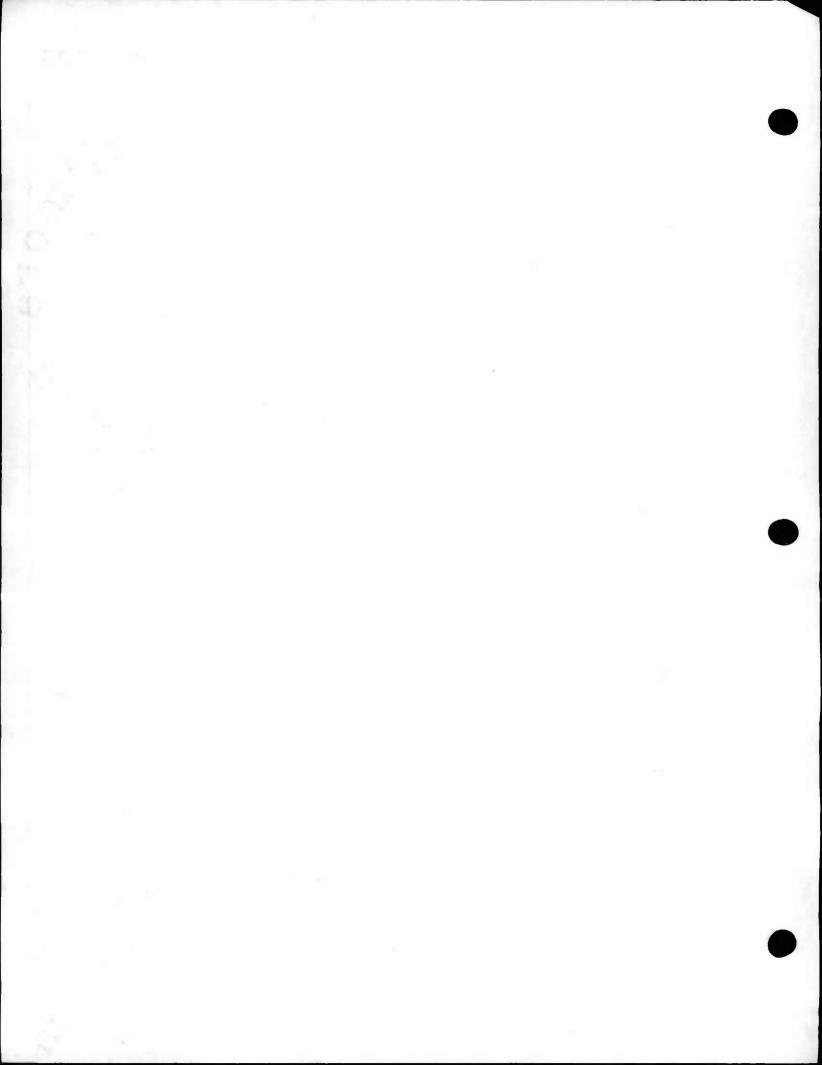
BE COMPLETED BY DUVEICIAN: MEDICAL CERTIFICATION

| | 1 - FOR STATE OF MA | | | | F HEALTH AND OF DEATH | | HYGIENE REG. NO. | | | |
|------------|--|---|-----------|---------------------------------|---------------------------|-----------------|---------------------|---------------|-------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 1 - | | | 2. DATE OF | DEATH | | | TIME OF DEATH |
| Î | George Holloway | Geor | 200 | Hollo | way. Jr. | MONTH 2 | DAY | | AR G | 57:45 AM |
| ļ | | AGE (In yrs. lesi | | IF UNDER 1 YE | | 7. DATE OF | | I A I | BIRTHPL | ACF (State or Foreign |
| 1 | The second secon | 75 | YRS. | MONTHS DA | YS HOURS MIN. | (Month, D | 1915 | 1 4 | Country) | Memphis. |
| Ì | 9e. FACILITY NAME (If not institution, give street and number) | 15 | | AL CITY TO | WN OR LOCATION OF D | | | 9c. COUNTY | | essee", |
| - | | | | | .ltimore | | - 1 | Sc. COUNTY | OF DEAT | 'n |
| 2 | Sinai Hospital | | | | | | | | | |
| DIMECTOR | 10e. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR L | OCATION | | | | 10 | d. INSIDE CITY |
| | Maryland | | | Ba.1 | timore C | litv | | LIMITS? | | |
| ا ي | 10e. STREET AND NUMBER | | | | 10f. ZIP CODE | | | | AT COUNTRY? | |
| 2 | 2010 Harrand Bank Arranti | 0 | | | 2120 | 7 | | US. | | |
| NEW PER | 3219 Howard Park Avenu | | MED | 13 WMS | DECENDENT OF HISPA | | Specify Year | v No 14 | _ | |
| | 1 Never Married 2 K Merried FORCES? 1 FYES, GIVE WAR | YES 2 N | 10 | If ye | s, specify Cuben, Mexic | an, Puerto Ric | | | | - Americen Indien, Vhife, etc. |
| 5 | 3 Widowed 4 Divorced | ON DATES | | '' | YES 2 NO Spec | ny. | | | Specify: | Black |
| | 15, DECEDENT'S EDUCATION | 16a, DE | CEDENT'S | USUAL OCCU | PATION | 18b. K | IND OF BUSI | NESS/INDUST | TRY | |
| | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Gi | Do NOT u | work done durli se retired.) | g most of working | | | | | |
| ₫ | | | | | | | | | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S N | AME (First, Mid | die, Maiden S | urname) | | |
| | George L. Holloway, S | r. | | | Alian | nelia | Holl | oway | | |
| 5 | 19e. INFORMANT'S NAME (Type/Print) | 198 | . MAJLING | ADDRESS (S | reet and Number or Rura. | l Route Number, | City or Town, | State, Zip Co | de) | |
| 2 | Hattie V. Holloway | 3: | 219 | Howan | d Park A | Avenue | e Bal | timo | re, | MD 21207 |
| | 20e. METHOD OF DISPOSITION 1Ž Burlal 2 □ Cremetion 3 □ Removal from State | 20b. PLACE | OF DISPO | SITION (Name | of cemetery, crematory or | | 20c. LOC | ATION — Cify | or Town | , State |
| | 1X Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) | Wood | | n Cem | etery | | Bali | timor | · e . | Maryland |
| ı | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | A | 22. NAI | NE AND ADDRESS OF F | | | | | |
| 1 | D = 0 1 0 1 0 | 1 00 | 1 | | oy O. Dy | | | | | |
| | Sing Cha | 1 | 1 | | 00 Libert | - | | | | |
| | 23. PART I. Enter the diseases, or complications that complete shock, or heart fallure. List only one cause | | | not enter the | mode of dylng, su | ch es cardia | c or respir | atory errest | , | Approximate Interval Between |
| ŀ | IMMEDIATE CAUSE (Fine) | | | | | | | | | Onset and Death |
| | resulting in death) a. No cou | chal I | fere | tion | | | | | | |
| Ì | | | | | | | | | | |
| 5 | Sequentially list conditions, | R AS A CONSE | مرحوو | cl | | | | | | |
| | if eny, leeding to immediate couse, Enter UNDERLYING | H AS A CONSE | JUENCE O | r): | | | | | | i l |
| HIFICALION | CAUSE (Disease or Injury | R AS A CONSEQUENCE OF): | | | | | | | - | |
| | that initiated events resulting in deeth) LAST | THE H CONCE | action o | • 1• | | | | | | j |
| ני ני | d | | | | | | | | | |
| ا يَ | PART II. Other significant conditions contributing to de | eath but not i | esulting | In the unde | riying cause given i | n Part I. 2 | 4a. WAS AN A | | | ERE AUTOPSY FINDINGS |
| 2 | | | | | | Ι, | PEHFOHR | | C | MAILABLE PRIOR TO OMPLETION OF CAUSE |
| MEDI | | | | | | | | | | F DEATH? |
| 2 | | | | | | | | | | |
| PHTSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PLACE OF DEATH (C | Check only one) | | | 1 | |
| ווי | EXAMINER? HOSPITAL: 1 ☐ YES 2 ☐ NO 1 ☐ Impatient 2 ☐ E | R/Outpatient 3 | □ DOA | OTHER: | Home 5 🗆 Residence | | Snecify) | | | |
| | 27. MANNER OF DEATH 28e, DATE OF IN | JURY | 28b. Til | NE OF 28 | c. INJURY AT | _ | | JURY OCCUP | RED | |
| | 1 Natural 5 Pending (Month, Day, | Year) | IN | JURY M | WORK? | | | | | |
| | 2 Accident Investigation 3 Suicide & Could not be 28e. PLACE OF | | me, farm, | street, factory | offica | 28f. LOCAT | ION (Street ar | nd Number or | Aural Aou | ute Number, |
| | 3 Suicide s Could not be 4 Homicide determined building, et | c. (Specify) | | | | City or | Town, State) | | | |
| | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of m | u basadada a | | | | -West 15th | | | | |
| COMPLEIED | (Check only one) 2 MEDICAL EXAMINER: On the basis of examiner | | | | • | | | | | and manner as stated. |
| 3 | | 2/ | | ,,, | | | | | | |
| מ | 296. SIGNATURE AND TITLE OF CERTIFIER | M | Λ | TAC | 29c. LICENSE N | 137000-1 | 02 | | IGNED (A | Aonth, Day, Year) |
| 5 | 20 MANS AND ADDRESS OF BERGOW WILL COMPANY | /· 1 | リー | JAI | 47-7-60 | 521-M | 1402 | | 1011 | |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE Decited Silia | | 1 1 | | , 0 1 | A | | | | |
| | | COLLINE | MC | 2719th | . Bal- | , / 11 | ٦. | | | |
| | 1 1 1000 V 1. K. | | 1,00 | | | | | | | |
| | DFC 11 1990 grilia Daire | May and May | | _ | | | | | | |



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| | . OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 mours after de | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi |
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| | | | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPART | MENT OF H | EALTH AND N | MENTAL HYGIEN | | | | |
|---|--|---------------|---|---|--|--|------------------|--|---|--|--|--|
| | | | 1. DECEDENT'S NAME (First, Middle, Last) | BESSIE | HYATT | | | 2. DATE OF DEATH DATE OF DEC. 6,19 | | | | |
| | | [. | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 6. B | 1:20 P. M INTHIPLACE (State or Foreign Journal) | | |
| | 2 | | | 1 🗆 M 2 🔀 F | 96 YRS. | MONTHS DAYS | HOURS MIN. | APR.12,18 | 94 | RUSSIA | | |
| - | 3 shor | DIRECTOR | 9e. FACILITY NAME (If not institution, give atra | | | | R LOCATION OF DE | ATH | 9c. COUNTY | | | |
| 5 | 85 1, 2, | | JEWISH CONVALESC RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | ENT CENTER | 40° CITA | TOWN OR LOCAT | PIMORE | | <u> </u> | LTIMORE | | |
| | ž | DIR. | MARYLAND | | | ALTIMORI | | 1 YES | | | | |
| 1 | fat permi | FUNERAL | 100. STREET AND NUMBER 2500 W. BELVEDER | E AVE., APT. | 516 | 101. | ZIP CODE 212 | 15 | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| 3745 | The <u>Durini</u> or | B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | If yes, spe | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | or No— 14. RACE — American Indian, Black, White, etc. Specify: WHITE | | | |
| 203 | 95 | 旦 | 15. DECEDENT'S EDUC. (Specify only highest grade of | NTION ompleted) | N st of working | 16b. KIND OF BUS | SINESS/INDUST | RY | | | | |
| 2120 solts or an | pe (tr | PLE | Elementary/Secondary (0-12) | College (1-4 or 5 +) | ille. Do NOT use | USEWIFE | | AT | HOME | | | |
| MARYLAND 2 | 8 6 | E COMPLET | 17. FATHER'S NAME (First, Middle, Last) ISAAC ROSENBE | RG | | <u> </u> | 18. MOTHER'S NA | ME (First, Middle, Meiden SARAH U | Surname) INKNOWN | | | |
| MARY e retained | | TO B | 190. INFORMANT'S NAME (Type/Print) MRS. JEANETTE BR | OWNSTEIN | | | | Route Number, City or Tow BOL BALTI | | | | |
| ORE, | funeral director, page xaminer must be | | 20e. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Remo 4 Donation 1 Other (Specify) | val from State | PLACE OF DISPOSE other place) ETH ISAA | C ADATH | ISRAEL | В | ALTIMOF | | | |
| BALTIMORE, N | the funeral dir oval. | | 21. SIGNATURE OF FUNERAL SERVICE LICE | Itillua | ~ | SOL | | N & BROS., STOWN RD. | | MD 21215 | | |
| D. O. BOX 13146, By configure the executed within a nours after | nding physician and completely filled in t Hygiene prior to burial, cremation, or re- or other traumatic event, the medi | CERTIFICATION | 23. PART ¹ . Enter the diseases, or contact, or heart failure. Limited in the contact is a second contact in the contact in th | SIST ONLY ONE CAUSE ON EAS A | | اعما | de of dying, suc | h aa cardlac or reap | Irationy arrest, | Approximate Interval Between Onset end Death | | |
| RECORDS, P. | signed by the Health and Mer ws any Injur | MEDICAL CE | PART II. Other eignificant conditions | contributing to death be | ut not resulting i | n the underlying | g cause given in | Part I. 24a, WAS AN PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 8 | as be Dept. | | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | |
| VITAL | ate ate | SICI | EXAMINER? | HOSPITAL: | etlent 3 DOA | OTHER: | ACE OF DEATH (Ch | 6 Other (Specify) | | | | |
| OF VIT | this certiful with the tree to an area to a tree to a tree tree tree tree tree tree tree tr | PHYSICIAN: | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 26b, TIMI | E OF 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| | | B | 1 Natural 5 Pending 2 Accident Investigation | 28e. PLACE OF INJURY | - At home form of | | YES 2 NO | 26f. LOCATION (Street | and Number or | Drumi Drum Akımbar | | |
| DIVISION | after 28 I | ETED | 3 Suicide 6 Could not be determined | building, etc. (Spec | ffy) | niest, iactory, orinc | • | City or Town, State | | THE POUL NUMBER | | |
| 5 | TAL OR ATTER TAL DIRECTOR 72 hours after 11 Item 28 | COMPLE | CONDUM CHAP | ZAN: To the best of my knowl | | | | | | ause(e) and manner as stated. | | |
| ž | 등 등 등 등 | BE | 296. SIGNATURE AND TITLE OF CERTIFIER | 20 | el. | _ n | 29 LICENSE NU | MBER 1686 | 29d. DATE SI | GNED (Month Day, Year) | | |
| | P 2 2 W | 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (7,00) | 1 1 0 | U M | . 0.6 | ,717 | Path one | | |
| | | | 31. DATE PILED (Month, Day, Year) 1990 | 32: REGISTRATI'S SIGN | -Handell | | - | | 64 | 21215 | | |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - REGISTRAR | | CERTIFIC | ATE OF DEATH | REG. NO. | | | | | |
|--|--|---------------------------------------|---|---|----------------------------------|---|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, | | 100 | ^ ^ | 2. DATE OF DEATH | YEAR | 3. TIME OF DEATH | | | |
| EVE | LYN | KLEF | f | 12 11 | 90 | 2 30 AH | | | |
| 4. SOCIAL SECURITY NUMBER | | . , | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | HPLACE (State or Foreign | | | |
| 217 12 3879 | 1 M 2 TF | 81 YRS. | NTHS DAYS HOURS MIN. | (Month, Day, Year) 11-7-190 | | laryland | | | |
| | spital Center | 96 | Baltimore | City | 9c. COUNTY OF | | | | |
| Harbor Hospital Center Baltimore City ======= RESIDENCE OF DECEDENT 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. LIMITS? Maryland Anne Arundel Glen Burnie 107 YES 2 | | | | | | | | | |
| | nne Arundel | | n Burnie | | LIMITS? | | | | |
| 10e. STREET AND NUMBER 6668 Shelly | C 23 | | 101. ZIP CODE 21061 | | WHAT COUNTRY? | | | | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 YE IF YES, GIVE WAR OF | ES 2 X NO | 13. WAS DECENDENT OF HISP/ If yes, specify Cuben, Mexic 1 YES 2 NO Spec | an, Puerto Ricen, etc.) | Ble | CE — American Indian, ck, White, atc. | | | |
| 15, DECEDENT'S (Specify only highest | EDUCATION | 18e. DECEDENT'S US | UAL OCCUPATION done during most of working | 16b. KIND OF BUS | SINESS/INDUSTRY | MILLE | | | |
| Elementary/Secondery (0-12) | College (1-4 or 5+) | Iffe. Do NOT use re | stired.) | Hut z | lers Den | t. Store | | | |
| 7th grade 17. FATHER'S NAME (First, Middle, La. | | balesia | | AME (First, Middle, Malden | | 0. 50010 | | | |
| 17. PATHER'S NAME (FIRST, MIDDIE, LE | • | Dianor | | mma Olivi | | | | | |
| 100 INFORMATIO NAME (T | Oliver H. | Disney | | | | | | | |
| 199. INFORMANT'S NAME (Type/Print) | | | ODRESS (Street and Number or Rura ourtland Drive | | | yland 21784- | | | |
| Naylor Kleff 200. METHOD OF DISPOSITION | T | | ON (Name of cemetery, crematory or | | CATION — City or | | | | |
| 1 🔯 Buriel 2 🗆 Cremation 3 🗆 | Removal from State | other place) | National Ceme | _ | | Maryland | | | |
| 21. SIGNATURE OF FUNERAL SERVI | | Daltimore | 22 NAME AND ADDRESS OF | ACH ITY | | | | | |
| · Gerome | mamica | whi | George J. Go | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | | | | | | | | | |
| PART II. Other significant con | ditions contributing to dest | h but not resulting in | the underlying cause given i | n Part I. 24e. WAS AN PERFO! | RMED? | Ab. WERE AUTOPSY FINDINGS ANALABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 25. WAS CASE REFERRED TO MEDIC EXAMINER? | | | 26. PLACE OF DEATH (| Check only one) | | | | | |
| 1 TES 2 NO | HOSPITAL: | | THER: Nursing Home 5 Residence | e 6 ☐ Other (Specify) | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending | | | | 28d. DEŞCRIBE HOW | 28d. DESCRIBE HOW INJURY OCCURED | | | | |
| 2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi | ot be 26e. PLACE OF INJ | URY — At home, ferm, stre Specify) | set, factory, office | 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| CHACK CITY | | | at the time, date end place, end d | | | e(e) end menner ee stated. | | | |
| 29b. SIGNATURE AND TITLE OF CE | ATTIFIER COMMISSION OF THE PROPERTY OF THE PRO | I- 1 | 29c. LICENSE N | UMBER | 29d. DATE SIGN | ED (Month, Day, Year) -//- 90 | | | |
| 30. NAME AND ADDRESS OF PERS | ON WHO COMPLETED CAUSE OF | F DEATH (ITEM 27) (Type, Pr | rbor Ho. | spital | Cost | Zi. | | | |
| 31. DATE FILED (Month, Day, Ybac) | 100 132. REGISTRAR'S | SIGNATURE PONDA | L | 101776 | cerv | ~ | | | |
| UEU1. | יושאיל אבבו ז | or turner. | | | | | | | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mours after death. Page 6 may be retained by the hospital or attending physician.

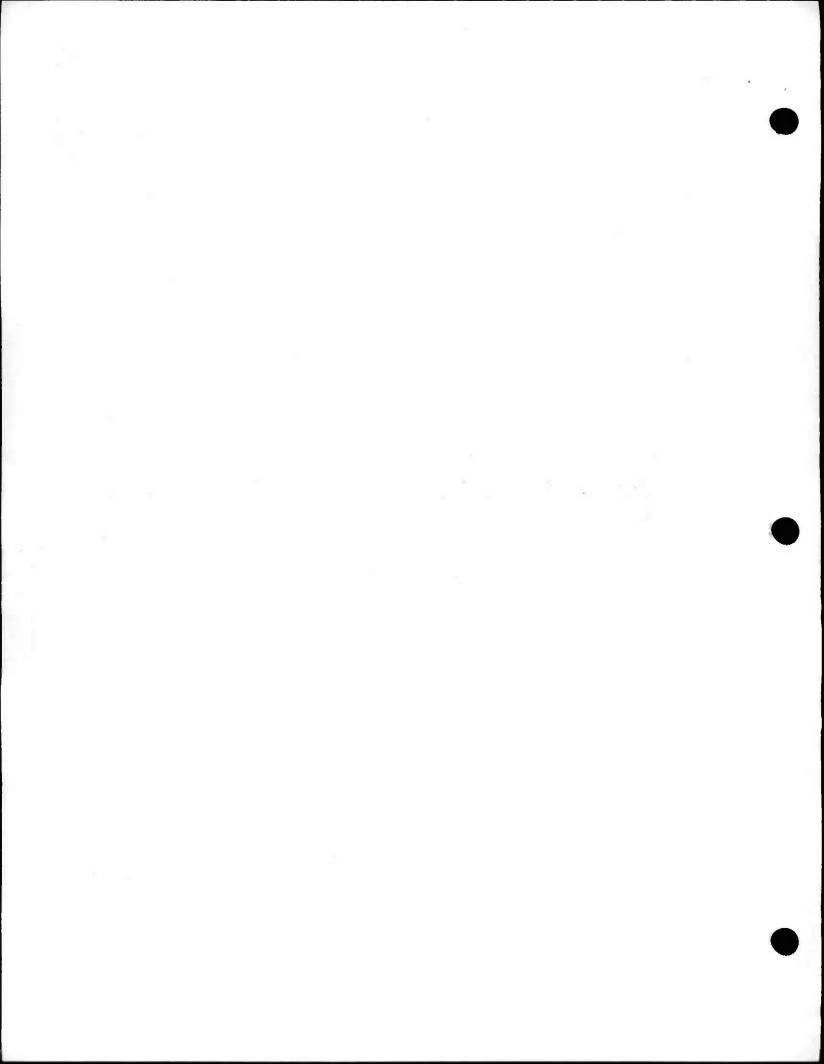
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | CATE OF DE | ATH | REG. NO | | | | | |
|--|--|--|---|---|---------------|---|----------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | KONDNE | | | 2. OATE OF DEATH MONTH | \$ - 90 | 2 //- | | | |
| | 4. SOCIAL SECURITY NUMBER 219-16-7501 | 1 🗆 M 2 💢 F | 72 YRS. | IONTHS DAYS HOUF | | 7. DATE OF BIRTH (Month, Day, Year) 4/2/191 | 8 | ethplace (State or Edition funtry) Maryland | | | |
| TOR | 99. FACILITY NAME (If not institution, give s Balto. CO. Gener | Carlotte Control | | Randal | | | 9c. COUNTY O | imore | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | v imore | | TOWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | | | |
| | 10e. STREET AND NUMBER | IMOLE | | Woodlawn | ODE | | 100 CITIZEN C | 1 YES 27 NO | | | |
| FUNERAL | 6610 Windsor Mil | | | | 212 | | Unite | d States | | | |
| B | 11. MARITAL STATUS 1 Never Merried 2 XXMerried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 XNO | | uben, Mexican | C ORIGIN? (Specify Yee, Puerto Ricen, etc.) | В | ACE — American Indien, Neck, White, atc. Pecify: White | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elamentary/Secondery (0-12) | CATION completed) College (1-4 or 5+) | 16a, DECEDENT'S U (Give kind of wo life. Do NOT use | SUAL OCCUPATION rk done during most of waretired.) | orking | 16b. KIND OF BU | SINESS/INDUSTR | Y | | | |
| APL | 12 years | College (1-4 or 5+) | Hous | ewife & Mo | ther | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | 18. N | OTHER'S NAM | AE (First, Middle, Maiden | Surname) | | | | |
| BE | John R. Thomas | | E-morrows and | | | na Meister | | | | | |
| 2 | Mr. Karl M. Kondi | ner | | Windsor Mi | | | | | | | |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSI | | | | ore, MD | | | | |
| | 1 Burial 2 Cremetion 3 Fem 4 Donetton 5 Other (Specify) | ovel from State | other placel | llawn Ceme | | | Woodlawn, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Home | | | | | | | | | | | |
| | James | 30 C 00 | \checkmark | | | Road Ran | | wn, MD 21133 | | | |
| 23. PART I. Enter the diseases, or complications that caused the death Do not enter the mode of dying, such as cardiac to abook or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | + ACZ | interval Between Onset and Daath Acty Long | | | |
| | PART II. Other significant condition | ns contributing to death | but not resulting in | the underlying cau | se given in l | | | 24b. WERE AUTOPSY FINDINGS | | | |
| EDICAL | Server | CANGES | TOUE P | toasy | F4'6 | UP TO YES | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| | DIABE | Tes m | - Elle Ten | <u>C</u> | | - | | 1 TES 2 NO | | | |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | | | OF DEATH (Che | ick only one) | | | | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/O | | OTHER: 4 Nursing Home 5 | Residence | 8 Other (Specify) | | | | | |
| BY PHYSICIAN: M | 27, MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJUR (Month, Day, Year | r) INJL | M 1 YES | | 28d, DESCRIBE HOW | INJURY OCCURE |) | | | |
| | 3 Suicida 8 Could not be 4 Homicide determined | 26a. PLACE OF INJU building, etc. (S | JRY — A1 home, farm, at specify) | reet, factory, office | | 281. LOCATION (Street City or Town, State | | iral Route Number, | | | |
| COMPLETED | CHOCK OTHY | SICIAN: To the best of my kn | | | | | | ise(e) end menner ee stated. | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | 5 | MD. | 2 | 195 | O1_ | 29d. DATE SIG | NED (Month, Day, Year) | | | |
| - | 30. NAME AND ADDRESS OF PERSON WI | Covan | sin my | | # 1 | RANDALIE | 15Zow | N Md 21133 | | | |
| | DEC 11 1990 Su | 132. REGISTRAR'S SI | | | | | | | | | |





permit. Pages 1, 2, 3

| r attending physician. | use as the burial-transit | |
|---|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit has find within 72 hours after death with the State Debt. of Health and Mental Honiene prior to burial, cremation, or removal. | otified at once. |
| ath. Page 6 may be | ineral director, page | aminer must be n |
| hin 2 mours after de | tely filled in by the furnation, or removal. | t, the medical ex |
| cate be executed with | hysician and complet e prior to burial, crer | er traumatic even |
| that the death certifi | ed by the attending part and Mental Hygien | any Injury, or oth |
| AN: The law requires | ificate has been sign. State Dept. of Healt | r Item 23 shows |
| ATTENDING PHYSICIA | CTOR: After this cert | 28 Is marked, o |
| TO THE HOSPITAL OR | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the fure has blad within 72 hours after death with the State Dent, of Health and Mental Honlene prior to burfal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REGISTRAR 1. DECEDENT'S NAME (Elmo "Siddle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 12 50 DAY HELEN D. KRAMER AM 10. 1990 DEC 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or For (Month, Day, Year) , 8-25-1905 DAYS HOURS : 🗆 M 2 💢 F 85 216-32-5266 YRS. MD 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR STELLA MARIS HOSPICE TOWSON BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? TOWSON 1 YES 2 XX MD. BALTIMORE FUNERAL 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 10f. ZIP CODE 2300 DULANEY VALLEY ROAD 21204 U.S.A. 12. WAS DECEDENT EVER INV.S. ARMED FORCES? 1 YES NO 11. MARITAL STATUS 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 \(YES 2 \) NO \(Specify: \) 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 Never Married 2 Married BY WHITE 3 Widowed 4 Divorced ETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highe Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 NURSE NURSING 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) HENRY KRAMER MARGARET EGAN BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Flural Route Number, City or Town, State, Zip Code) 3425 EAST NORTHERN PKWY. BALTIMORE, MD. 2 MARIE E. HALEY 20a. METHOD OF DISPOSITION

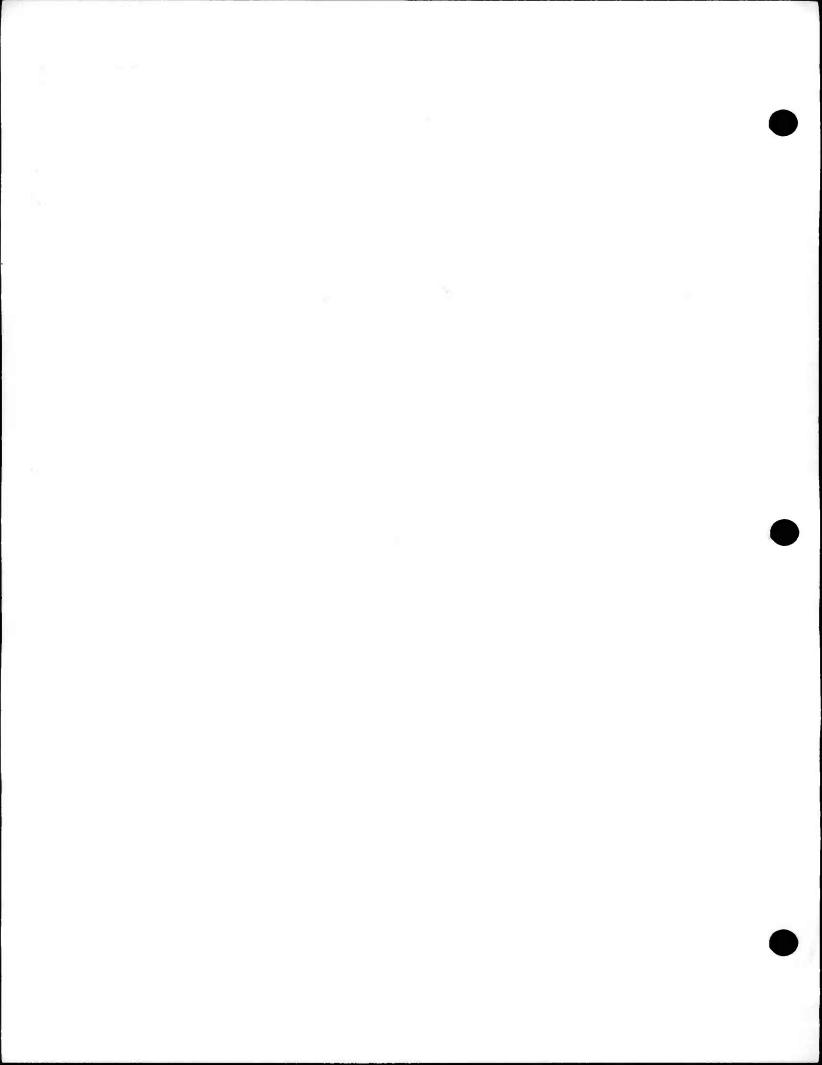
Burial 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or 20c. LOCATION — City or Town, State PARKWOOD CEMETERY BALTIMORE, MD. 21234 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
HENRY W. JENKINS AND SONS 21212 in 4905 YORK ROAD. BALTIMORE, MD. 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ahock, or heart fallure. List pnly pne cause on each line. Interval Betwe Onset and Death **IMMEDIATE CAUSE (Final** disease Dr condition Nã Tura reaulting in death) Scleratic Cardio Vascular Disease CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO **PHYSICIAN:** 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 TES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ome 5 🗆 Residence 6 🗀 Other (Specify) 27. MANNER OF DEATH 28s. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 29a, CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 2 MEDICAL EXAMINER: On the basis of examin ition and/or investigation, in my opinion, death oc 29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 027087 190 10 devil 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

e

1990

32. REGISTRATE SIGNATURE Pandage





nsit permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the function of the property of the function of the fun IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MAR | | | HEALTH AND N F DEATH | MENTAL HYG | | 30 34029 | |
|---------------|---|---|-----------------------------------|--|---|---|--------------------------------|---|--|
| , | 1. DECEDENT'S NAME (First, Middle, Lest) | Klinghon | Hertcla | IRE KLI | NGHOFFER) | 2. DATE OF DEAT | TH DAY | YEAR 3. TIME OF DEATH 90 33 17 M | |
| | 4. SOCIAL SECURITY NUMBER 181-10-5153D | 5. SEX 6. A | GE (In yrs. last birthda) 77 YRS. | MONTHS DAY | | 7. DATE OF BIRT (Month, Day, Ye | н 71913 | 8. BIRTNPLACE (State or Foreign Country) PENNSYLVANIA | |
| _ | 9e. FACILITY NAME (If not institution, give)s | | 10/ | 9b. CITY, TOW | N OR LOCATION OF DE | | 9c, 90UN | TY OF DEATH | |
| CTO | SI. JOSEPH | Buspi | THE | 1/00 | | | PA | | |
| DIRECTOR | MARYLAND 10b. COUNTY | BALTIMORE | 10c. C | TY, TOWN OR LO | CATION LOWSON | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO | |
| FUNERAL | 1705—C ABERDEEN | | | | | | 10g. CITI | ZEN OF WHAT COUNTRY? | |
| à | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 X Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | /ES 2 (100 | If yes | 21204 DECENDENT OF NISPAN specify Cubert, Mexice (ES 2 X NO Specify | IIC ORIGIN? (Speci n, Puerto Ricen, et | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | (Give kind of life. Do NOT | "s usual occup of work done during use retired.) SEWIFE | | 16b, KIND C | OF BUSINESS/IND | HOME | |
| | 17. FATNER'S NAME (First, Middle, Last) HARRY WEINTRAUB | | | | 18. MOTHER'S NAI | | falden Surname) | | |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) | | | | et and Number or Rural I | - | | | |
| | HERBERT KLINGHOF 208. METHOD OF DISPOSITION | | 20b. PLACE OF DISF | | AN CIR., A | | BALTO. | , MD 21239 City or Town, State | |
| | 1 X Buriel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | | other place) | L MEMOR | IAL PARK | | RANDA | LLSTOWN, MD | |
|) | 21. SIGNATORE OF PUMERAL SERVICE LI | 1. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., M | | | | | | | |
| | 23. PART / Enter the diseases, or shock, or heart failure. | complications that ca | used the death. Do | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Due to lon as a consequence of: | | | | | | | | |
| MOIT | Sequentisliy list conditions, if any, leading to immediate cause, Enter UNDERLYING | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | PART II. Other significant condition | ns contributing to dee | oth but not resulting | g in the under | ying ceuse given in | | AS AN AUTOPSY ERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| MEDICAL | - Delles | ~2 C | 3 rue | d | tene | > | YES 2 NO | COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | |
| AN: | 25. WAS CASE REFERRED TO MEDICAL | | | > | 3. PLACE OF DEATN (Ch | eck only one) | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | /Outpatient 3 🗆 DO/ | OTHER: | Nome 5 - Residence | | fy) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJ (Month, Day, Y | URY 28b. | INJURY | INJURY AT WORK? | 28d. DESCRIBE | HOW INJURY OC | CURED | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28e. PLACE OF IN building, etc. | JURY — At home, fari (Specify) | m, atreet, fectory, | office | 281. LOCATION (City or Town | (Street and Number , State) | e or Rural Route Number, | |
| COMPLETED | (Orlock Orly) | ICIAN: To the best of my | | | | | | nted. The couse(e) and manner se stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | min | id | | 29c LICENSE NUI | MBER | 29d. DAT | TE SIGNED (Month, Day, Yegr) | |
| ۴ | 30. NAME AND ADDRESS OF PERSON W | NO COMPLETED CAUSE O | DEATH (ITEM 27) | Ph. | id | | | | |
| | 31. DATE FILED (Month, Dey, Year) DEC 11 1990 | guilla Davidos | | | | | | | |

| BALLIMORE, MARTLAND | rithin 24 nours after death. Page 6 may be retained by the hosp | letely filled in by the funeral director, page 5 should be detached | ent, the medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOA 13149, | TO THE HOSPIT OF ALLEGON, Physician: The law requires that the death certificate be executed within 2s mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIFFERDS AND THE certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and activities of the companient of removal | De med within 1 deposits proceed with the State Cept. Or regult and mental stylene provide count, commont, or remova. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| CIVID | TO THE HOSPITAL OF ALTER | TO THE FUNERAL DIPECTOR | IMPORTANT: If Item 28 |

| | FOR 1 - STATE REGISTRAR | STATE OF M | MARYLAND / | | | OF HEALTH | | | YGIEN EG. NO. | | U J | 4030 |
|--------------------|--|--|---|-------------------------------------|--------------|-----------------------------|------------|------------------------------------|------------------|---|--------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) TELFAIR C | CHARLES | TELFAI | R LE | IMBACI | I JR. | | 2. DATE OF MONTH | DA | | 90 3. T | OY/5 M |
| | 4. SOCIAL SECURITY NUMBER 212-05-3717 | 5. SEX 1 M 2 F | birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. WONTHS DAYS HOURS MIN. | | | | | | Country) | CE (State or Foreign | | |
| | 9a. FACILITY NAME (If not institution, give si | reet and number) | 1 | | 9b. CITY, T | OWN OR LOCAT | TION OF DE | | 0,0 | 9c. COUNT | | 1 |
| DIRECTOR | Union Memorial | Extend | led Car | e U | pit | Bal | timo | ore | | | N/A | |
| 2 | 10a. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN OR | LOCATION | | | | | 10d | . INSIDE CITY |
| PIR | MD N/ | 'A | | | Balt | imore | | | | I was a second | | LIMITS? X YES 2 \(\square\) NO |
| FUNERAL | 407 Wingate R | oad | | | | 10f. ZIP COI | 1210 |) | | ļ * | SA | COUNTRY? |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | | | | S DECENDENT | | | | or No- 14 | 4. RACE — / Black, Wi | American Indian, |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE V | YES 2 N | /A | | res, specify Cub | | | n, etc.) | | Specify: | White |
| COMPLETED | 15. DECEDENT'S EDU((Specify only highest grade) | CATION completed) College (1-4 or 5 | (G | CEDENT'S ive kind of Do NOT u | Work done du | UPATION ing most of work | idng | 16b. KIN | ID OF BUS | SINESS/INDUS | STRY | |
| MPL | | 5+ | | ecto | r of 1 | laceme | | | | | E Bal | timore |
| S | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MO | THER'S NA | ME (First, Midd | le, Maiden | Surname) | | |
| BE | C. Telfair L | eimbach | | | | | _ | nnell | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Wendell B. Leimba | ch | | | | Street and Numb | | | | | | |
| | 20. METHOD OF DISPOSITION | | | | | of cemetery, are | | morcy | , | CATION — CI | - | State |
| | Maryland Cremetton 3 Removal from State Connection 5 Con | | | | | | | | | | | |
| | 21. SIGNAPORE OF FUNERAL SERVICE SIG | Mena | ki | - | M | tchell | -Wie | defeld | | | | |
| 11.5 | Dennis Steph | · | | | | Ltimore | _ | | | | | York Rd. |
| | 23. PART I. Enter the diseases, or one shock, or heart failure. IMMEDIATE CAUSE (Final | complications the List only one car | it caused tha de use on aach line | ath. Do | not enter ti | ne mode of d | ying, suc | h as cardiac | or respi | iretory arrea | nt, | Approximate interval Between Onset and Death |
| | disease or condition resulting in death) STAPHYLOCOCCAL SEPSIS DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| _ | | | MEINARY TRACT INFECTION | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | (OR AS A CONSE | DUENCE C | OF): | | | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury | | CENIC BLADDER | | | | | | | | | |
| # | that initiated events resulting in death) LAST | DUE TO | (OH AS A CONSE | JUENCE C | л-): | | | | | | | |
| 8 | | d | | | | | | | | | | |
| PHYSICIAN: MEDICAL | CORFBROVASCULAR DISEASE PERFORMED? 1 YES 2 NO OF DE | | | | | | | | | RE AUTOPSY FINDINGS NILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PLACE OF | DEATH (C) | neck only one) | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: | ☐ ER/Outpetlant 3 | □ DOA | OTHER: | | | V | necify) | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, I | DATE OF INJURY (Month, Day, Year) 286. TIME OF 28c. INJURY AT WORK? 28d. DESCRI | | | | | | | INJURY OCCU | JRED | |
| >- I | 2 Accident Investigation | 28s. PLACE OF INJURY — At homa, farm, street, factory, offica 28f. LOCATION (Street and Number or Rural Ro City or Town, State) | | | | | | | r Rural Route | e Number, | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be detarmined | 28a. PLACE (building | atc. (Specify) | | | | | 0,70,7 | Davis, Otalo, | , | | |
| | 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only | building | , atc. (Specify) f my knowledge, de | eath occur | | | | to the cause(| a) and ma | nner as stated | | |
| BE COMPLETED BY | 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only | ICIAN: To the best of | , atc. (Specify) f my knowledge, de | eath occur | | nion, death occ | | a to the cause(a time, data an | a) and ma | nner as states | cause(a) an | id manner as stated. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

mi.

21218

BARTIMORE,

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

Flovann LOVENSO 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 12-18-1948 38 039 1 M 2 D F 44 New Jersey permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9h, CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore DIRECTOR Loch Raven VAMC RESIDENCE OF DECEDENT 10c CITY TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? Baltimore 1 X YES 2 NO Maryland FUNERAL 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER 21214 USA 6613 Touchstone Court be detached for use as the burial-transit 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 \boxtimes YES 2 \square NO IF YES, GIVE WAR OR DATES 7-2-66/7-17-7011. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 X Merri B 3 Widowed 4 Divorced White ETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 1yr Auto Carrier Manager 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Sumame) "Unknown to Records! "Unknown to Records" notified at page 5 should 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 6613 Touchstone Ct., Balto., MD 21214 Angela LoVerso must be 20a. METHOD OF DISPOSITION
1 Durial 2 X Cremation 3 Ren 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State funeral director, Balto., Maryland Metor Crematory, Inc. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE DEENSEE 22. NAME AND ADDRESS OF FACILITY
Cremation Society of Maryland examiner George E. MacNabb 299 Frecerick Rd., Balto., MD 21228 signed by the attending physician and completely filled in by the Health and Mental Hygiene prior to burial, cremation, or removal. medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ehock, or heart fellure. Liet only ona ceuse on each line Interval Batw IMMEDIATE CAUSE (Final Onset and Death the disease or condition 4 hour ny REMIRAL and OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within reaulting in death) other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): num CERTIFICATION Sequantially list conditions, if eny, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF) 105 . Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 0 Injury, PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 23 shows any DE DEATH? 1 YES 2 NO has been s Dept. of H PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) He H EXAMINER? FUNERAL DIRECTOR: After this certificate I within 72 hours after death with the State HOSPITAL: OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 - Nursing Home 5 - Realdence 8 - Other (Specify) 6 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident
3 Sulcide 26a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, 9 ETED. 6 Could not be datarmined Item 28 4 Homicide 29a. CERTIFIER
(Check only one)

2 MEDICAL EXAMINES: On the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as atteted. COMPL TO THE HOSPITAL OF THE FUNERAL DID BE filed within 72 hr HOSPITAL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated, 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) B 9 30. NAME AND ADDRESS WHO COMPLETED CAUSE DF DEATH (ITEM 27) (Type, Print) Mai 31. DATE FILED (Month

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Giovanni (NMN) Loverso.

REG. NO

2. DATE OF DEATH 11-30-

3. TIME OF OEATH

lo

REG. NO

2. DATE OF DEATH

FOR

STATE REGISTRAR

1 DECEDENT'S NAME (First Middle Last

requires that the death certificate be executed within OR ATTENDING PHYSICIAN: The law

1 Z Charles Linder Sr. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR | IF UNDER 24 HRS. July 22 1927 DAYS 217-24-9904 1 0 2 D F 63 Maryland YRS permit. Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Loch Raven V.A. Hospital Baltimore City RESIDENCE OF DECEDENT 10h COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY Maryland Baltimore City 1 X YES 2 | NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? filled in by the funeral director, page 5 should be detached for use as the burial-transit ion, or removal. 3706 Monterev 21218 United States Road 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, rws DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuban, Maxican, Puarto Rican, atc.)

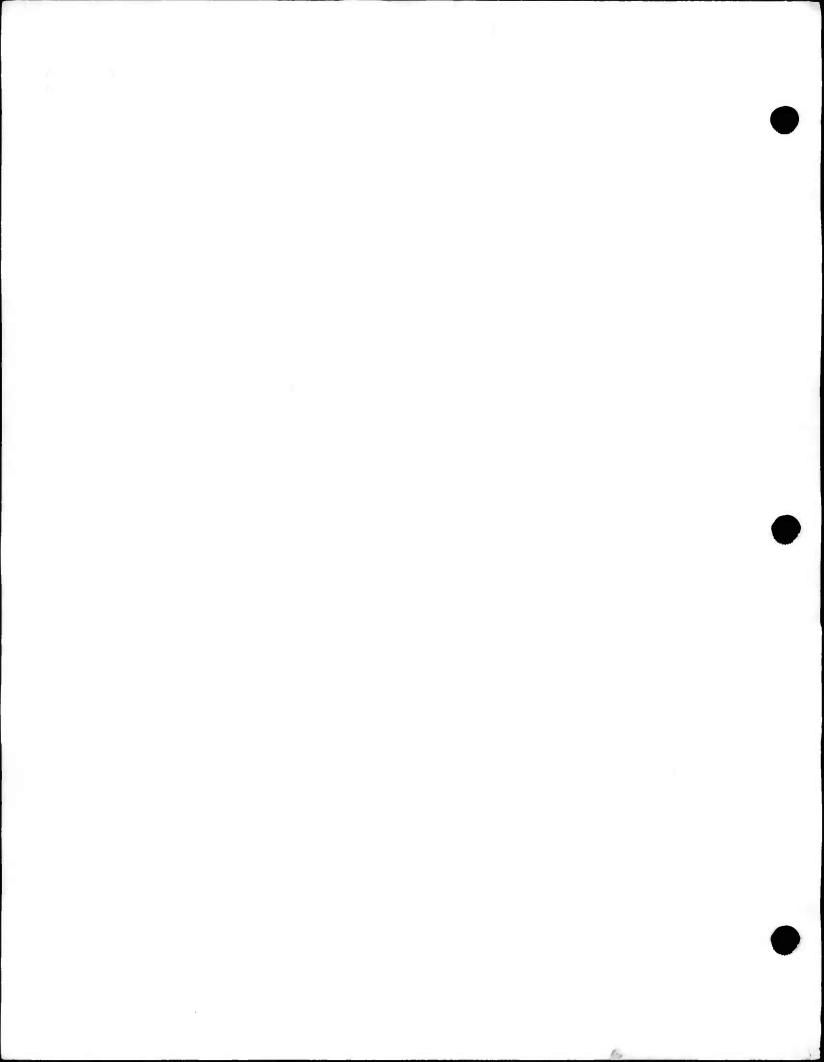
1 ☐ YES 2 ☒ NO Specify: 1 Never Married 2 X Married В 3 Widowed 4 Divorced White Korean COMPLETED 18s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INQUSTRY (Specify only high Elamentary/Secondary (0-12) 8 **B&ORR** Electrician 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Elizabeth Linder Kriner notified at BE (Edgar 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19s. INFORMANT'S NAME (Type/Print) 2 Mary A. Linder 3706 Monterey Road Baltimore, Md. 21218 pe 20a, METHOD OF DISPOSITION
1 🔀 Burial 2 🗆 Cremation 3 🗆 Ram 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State must Dulaney Valley 12/11/90 Timonium, Md. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Paul L. Hartsock, Jr. 21214 Leonard J. Ruck, Inc. 5305 Harford Road medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory street, Approximate shock, or heart failure. List only one cause on each line Intarval Batween 6 IMMEDIATE CAUSE (Final Onsat and Death i signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, the disease or condition Longestire resulting in death) traumatic event, CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, lasding to immediata cause. Entar UNDERLYING CAUSE (Disease or Injury (whose) pahe or other DUE TO (OR AS A CONSEQUENCE OF) that initiated eventa resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COPD 23 shows any COMPLETION OF CAUSE 1 TYES 2 NO DE DEATH? 1 TYES 2 NO has been s Dept. of H PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF OEATH (Check only one) r this certificate h OTHER: 1 TES lant 2 ER/Outpatient 3 DOA 4 - Nursing Home 5 - Raeldanca 8 - Other (Specily) 0 28b. TIME OF NJURY 27. MANNER OF DEATH 28c. INJURY AT WORK? DATE OF INJURY 28d. DEŞCRIBE HOW INJURY OCCURED marked, Natural Accident IA 1 YES 2 NO В FUNERAL DIRECTOR: After twithin 72 hours after death 28a, PLACE OF INJURY — At he 281. LOCATION (Street and Number or Rural Route Number, 60 3 Sulcida 6 Could not be COMPLETED Item 28 4 Homicide determined 1 SCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated. (Check only one) IMPORTANT: II 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occursd at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER

SOLE COST 29d. OATE SIGNED (Month, Day, Year) H H 42 8 9 OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HOLPHAR OF MD. SOF 32. BEGISTRAM'S SIGNATURE a Davidson-Randell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

OHMH-16 Rev 1/89



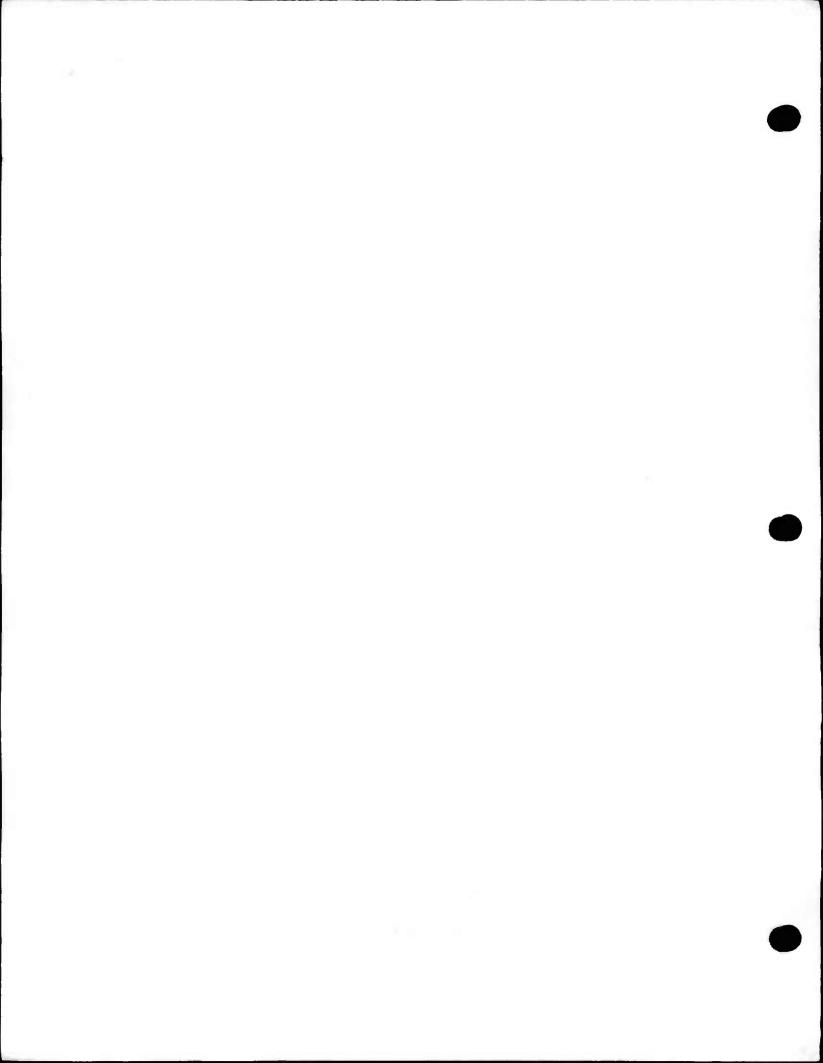
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFI | CATE O | DEATH | RE | G. NO. | | | | |
|------------------|--|--|----------------------------|-----------------------------------|---|---|------------------------------|--------------------|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | Richard | D. Lind | leav S | r | 2. DATE OF OE | вач 199 | YEAR | 3. TIME OF DEATH 2 10 A M | | |
| | | | (In yrs. lest birthday) | IF UNDER 1 YEAR | - | | | | | | |
| | 213-07-3190 | 1 🖄 M 2 🗆 F | 82 YRS. | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIF (Month, Day, 8 - 8 - | 1908 | S. BIHTF Counti | HPLACE (State or Foreign ny) V a | | |
| E I | 90. FACILITY NAME (If not institution, give street 4046 Boarman | | | | or Location of DE timore | HTA | 9c. COL | INTY OF D | DEATH | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| H | 100. STATE Md 10b. COUNTY | | | , TOWN OR LOC | | | | | 10d. INSIDE CITY LIMITS? | | |
| ā | | | B g | altimor | | | | | 1XXYES 2 □ NO | | |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 4046 Boarman Aver | nue | | | 21215 | | | S A | WHAT COUNTRY? | | |
| 3 | | 2. WAS DECEDENT EVER I | | | CENDENT OF HISPAN | | | 14. RAC | E — American Indien, k, White, atc. | | |
| à l | 1 Never Merried 2 Nerried 3 Widowed 4 Olvorced | FORCES? 1 YES | | | specify Cuban, Mexice S 2 NO Specify | | etc.) | Spec | | | |
| 입 | 15. DECEDENT'S EDUCA (Specify only highest grade co | FION | 16a. DECEDENT'S | USUAL OCCUPA | TION | 18b. KINO | OF BUSINESS/IN | DUSTRY | | | |
| COMPLETED | | College (1-4 or 5+) | life. Do NOT us | vork done during i e ratired.) | nost of working | | | | | | |
| ₹ | 17. FATHER'S NAME (First, Middle, Last) | | | - | 18. MOTHER'S NA | ME (Einst Middle | Maldon Sumama) | | | | |
| BE C | Richard D. Lindsa | ay . | | | To MOTTELL OTTO | The (First, Micolo, | walcon ounemey | | | | |
| 10 8 | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | end Number or Rural | Route Number, Cit | y or Town, State, Z | ip Code) | | | |
| ۲ | Richard Lindsay, o | Jr | 4046 | Boarma | n Avenue | Baltim | lore, Md | 212 | 15 | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation Service 4 Donation 6 Other (Specify) | al from State | other place) WOOD Tawn | Cemete | remetery, cramatory or | | Baltimore, Md | | | | |
| - 1 | 21. SIGNATURE OF EUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | |
| | 1) on 3. | al | | | ch F/h We | | ша | | | | |
| П | 23. PART I. Enter the diseese, or co | mplications that cause | d the death. Do n | | | | | rrest, | Approximete | | |
| | shock, or heert felidre. List only one cause on each line. IMMEDIATE CAUSE (Finel Onset end Deeth | | | | | | | | | | |
| | disease or condition resulting in deeth) | Acceste | Per los | renerry | Eden. | ~ | | | LIL | | |
| | resulting in deetil) | DUE TO (OR AS | A CONSEQUENCE OF | 7): | | , | | | 116 | | |
| Z | Sequentially list appolitions b. Myocardesk Inferestion | | | | | | | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentielly liet conditione, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury CAUSE (Disease or injury Onset end Deeth L + L L + L Due TO (OR AS A CONSEQUENCE OF): A C C C C C C C C C C C C C C C C C C | | | | | | | | | | |
| 5 | | DUE TO (OR AS | A CONSEQUENCE OF | 3. | | | | | | | |
| Ē | thet initieted evente resulting in death) LAST | DUE TO (OR AS | A CONSECUENCE OF | 7. | | | | | i | | |
| 빙 | d. | | | | | | | | | | |
| 4 | PART II. Other eignificent conditions | contributing to deeth | but not resulting | in the underly | ing ceuse given in | | WAS AN AUTOPSY PERFORMED? | 241 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| EDICAL | COMPLEX V | PC | | | | | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? | | |
| MEI | Complex V Deolesso Es | reform p.po | thy x | nec | uspear | | | | 1 YES 2 NO | | |
| | Hypertem | en to | -VH | | · | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | UCCDITAL. | | | PLACE OF OEATH (Ch | neck only one) | | | | | |
| SIC | | HOSPITAL: 1 Inpetient 2 ER/Out | patient 3 DOA | OTHER: 4 - Nursing H | ome 5 🗆 Residence | 8 Other (Spec | cify) | | | | |
| 됩 | 27. MANNER OF DEATH | 2Se. DATE OF INJURY (Month, Day, Year) | 28b. TIM | | NJURY AT WORK? | 28d. OEŞCRIBI | HOW INJURY O | CCURED | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | M 1 | YES 2 THO | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJUR building, atc. (Spe | Y — At home, farm, socity) | | fice | 281, LOCATION City or Tow | (Street and Numb | er or Rural | Floute Number, | | |
| | 4 Homicide determined | | 7767012 | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICI | AN: To the best of my know | wiedge, death occurr | ed at the time, d | ate end place, end due | to the cause(e) | end menner as si | ated. | | | |
| 8 | one) 2 MEDICAL EXAMINER: | On the basie of examination | on end/or investigation | n, in my opinior | , death occured at the | time, date end p | olece, end due to | the ceuse | (e) end menner ee stated. | | |
| EC | 296. SIGNATURE AND TITLE OF CERTIFIER | 2 | tan.y | | 29c. LICENSE NU | MBER | 29d. DA | TE SIGNE | O (Month, Day, Year) | | |
| 00 | ac au | er man | phy 10 | Leez | 015 | 217 | • | 12/ | 11/96 | | |
| 2 | 30. NAME AND A OORESS OF PERSON WHO | COMPLETED CAUSE OF D | EATH (ITEM 27) (Type | | of PA | Day | ia. Mi | d - | 71123 | | |
| | 31. DATE FILEO (Month Day, Her) 4 | 32. REDISTRAR'S ING | NATURE 😘 | | 1 4.10 | · Kur | W. MI | A | | | |
| | OFC 11 199 | 14 guka Deur | don-Hande | | | | | | | | |



FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

296. SIGNATURE AND TITLE OF CERTIFIER

1990

31. DATE FILED (MOTO), Day, 1

| 13146 |
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| BOX |
| P.0. |
| RECORDS, |
| OF VITAL |
| DIVISION |
| |

Caroline Clara Michelmann 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. DAYS 212 07 0698 82 permit, Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE Long Green Nursing Home Baltimore DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE MD Baltimore FUNERAL 10e, STREET AND NUMBER 10f, ZIP CODE 2121 324 E. Belvedere Ave. page 5 should be detached for use as the burial-transit nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 13. WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexics 1 ☐ YES 2 ☒ NO Specifi 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 3 Widowed 4 Divorced ED 16a, OECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade comple Щ Elementary/Secondary (0-12) College (1-4 or 5+) Statistician COMPL once. 18. MOTHER'S NAI 17. FATHER'S NAME (First, Middle, Last) Harry Michelmann Wilhe 듉 BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural I Mrs. Harriett M. Little 2600 Whitney Ave. pe 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20a. METHOD OF DISPOSITION 20s. METHOD OF DISPOSITION

1 State | Donation | Disposition | Donation | Disposition | Dispositi must certificate has been signed by the attending physician and completely filled in by the funeral director, the State Dept, of Health and Mental Hygliene prior to burial, cremation, or removal. Moreland Memorial Park examiner 21. SIGNATURE OF PUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FA MITCHELL-WIE C. Sherman Denny, Jr, 6500 York Ro the medical 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, suc shock, or heart fellure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) within event, DUE TO (OR AS A CONSEQUENCE OF): executed or other traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Pe certificate CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST shows any injury, PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in MEDICAL that PHYSICIAN: AMP. Item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Ch The **EXAMINER?** HOSPITAL:
1 | Inpetient 2 | ER/Outpetient 3 | DOA 1 TES 2 NO ATTENDING PHYSICIAN: Home 5 - Residence 6 L DIRECTOR; After this cert 2 hours after death with the filem 28 is marked, o 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? Natural 6 Pending investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — building, etc. (Specify) 3 Suicide a [Could not be COMPLETED 4 🗌 Homicide OR N 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due TO THE HOSPITAL OF THE FUNERAL D BE filed within 72 ho 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

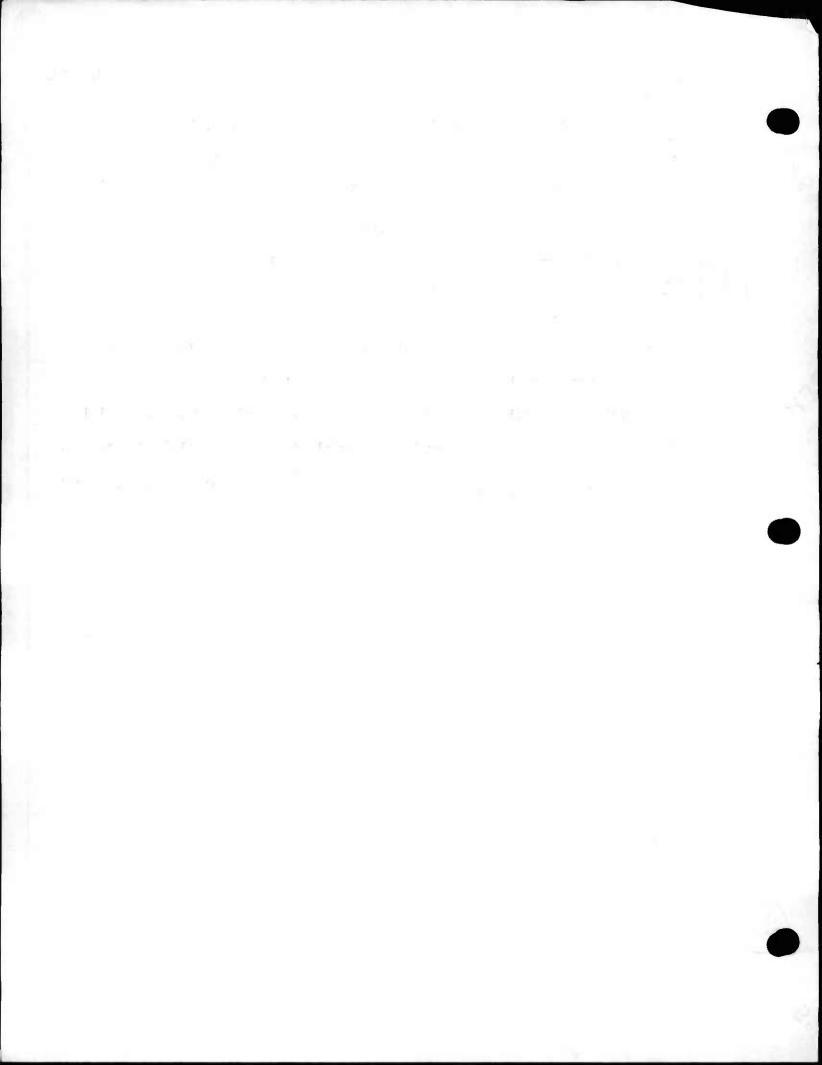
32 MEDISTRATS SENATURA CONTRACTOR

90 34034

| STATE OF MARYLAND | DEPARTMERTIFIC | MENT OF H | EALTH AND DEATH | MEN | TAL HYGIENE REG. NO. | J | U | 34034 | | | |
|---|--|----------------------------|--------------------------------|----------|--|----------------------------|--------------------|--|--|--|--|
| ne Clara Miche | lmann | | | 2. D | ate of Death | 3. TIME OF DEATH 8. 30 PM | | | | | |
| 6. SEX 6. AGE (In yrs. In | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | Jai | ATE OF BIRTH North, Day, Year) | 8 | 8. BIRTH Countr | PLACE (State or Foreign MD | | | |
| ing Home | 98 | Balti | more | EATH | | 9c. COUN | TY OF D | EATH | | | |
| | | own on Locat | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| re Ave. | WHAT COUNTRY? | | | | | | | | | | |
| 2. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 X IF YES, GIVE WAR OR DATES | E — American Indian, t, White, atc. ty: 1 te | | | | | | | | | | |
| TION 16a. (Impleted) 16a. (College (1-4 or 5+) | ity | | | | | | | | | | |
| ichelmann Weber | | | | | | | | | | | |
| Little | Little 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2600 Whitney Ave. Baltimore, Md. 21215 | | | | | | | | | | |
| 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or other place). Moreland Memorial Park 20c. LOCATION – City or Town, State Baltimore Co., Md. | | | | | | | | | | | |
| enny, Jr | MITCHELL-WIEDEFELD HOME, INC. | | | | | | | | | | |
| pulcations that caused the caused in the cause on each life pulcation of the cause on each life pulcation (or as a constitution of the caused on the caused | EQUENCE OF: | | SE SE SE V. | | heck | orbid Trans | eat, | Approximete Interval Between Onset and Death | | | |
| DUE TO (OR AS A CONS | EOUENCE OF): | | | | | | | | | | |
| contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DE DEATH? 1 YES 2 NO | | | | | | | | | | | |
| HOSPITAL: | 1 | 26. PI | LACE OF DEATH (C | check or | nty one) | | | | | | |
| 1 □ Inpetient 2 □ ER/Outpatient 28a. DATE OF INJURY (Month, Day, Year) | | Nursing Hon OF 28c. IN. | JURY AT DRK? YES 2 NO | | Other (Specify) . DESCRIBE HOW I | NJURY OC | CURED | | | | |
| 26e. PLACE OF INJURY — At building, etc. (Specify) | home, farm, str | set, factory, offic | ÷0 | 281. | LOCATION (Street of City or Town, State) | and Number | r or Rural | Route Number, | | | |
| IAN: To the best of my knowledge, | | | | | | | | (e) and menner as stated. | | | |
| 9 1/ 5 | // | | 29c. LICENSE N | UMBER | /(- | 29d. DAT | E SIGNE | (Month, Day, Year) | | | |



出 9



YEAR 90

3. TIME OF DEATH

Approximets Interval Between Onset end Death 6 me

A M

2. DATE OF DEATH MONTH 12

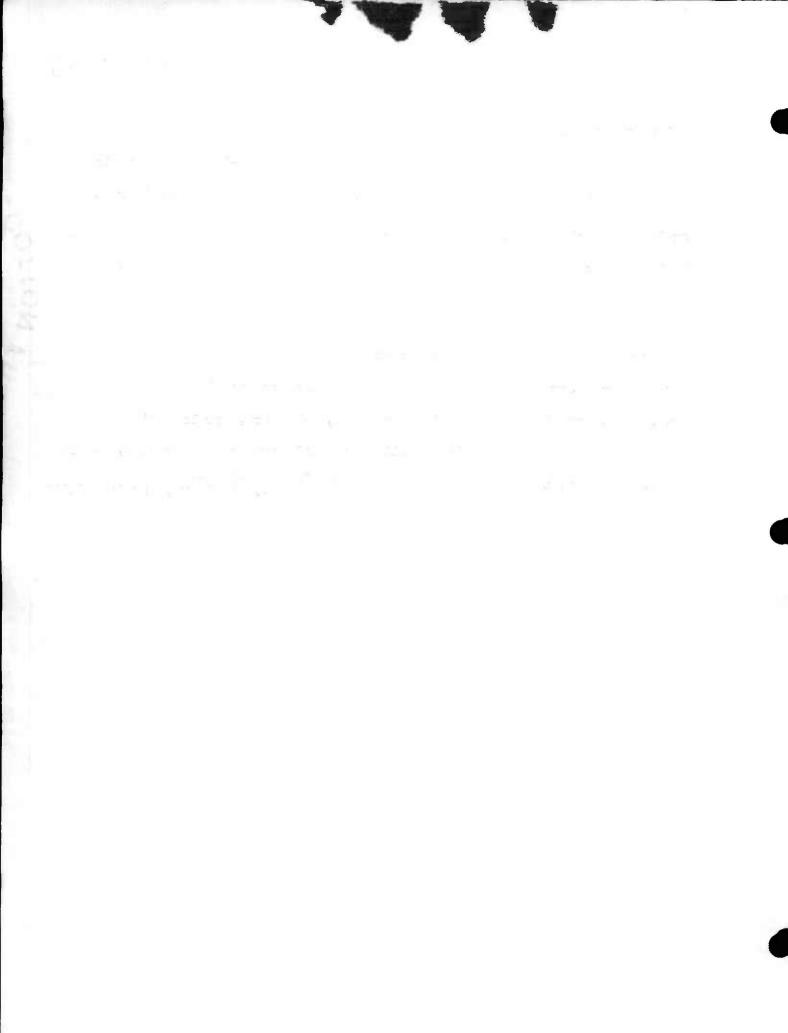
DECEDENT'S NAME (First, Middle, Last)

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| | | Elva Mae Markel | | | | | | | | 12 | O | | 90 | A |
|--|---------------|--|-------------------------|---------------|--|---|-----------|---------------------|------------|----------------------------|-------------------------|------------------------------------|----------------------|--|
| - 1 | i | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. last birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF E (Month, De | y, Ybar) | | BIRTHPLA Country) | CE (State or Foreign |
| P | | | 1 🗆 M 2-XXF | 6 | 5 YRS. | | | | | | 2-25 | | | land |
| 2, 3 should | ~ | 9a. FACILITY NAME (If not institution, give s | treet and number) | | | | | OR LOCATIO | ON OF DEA | тн | | Baltimore County | | |
| | ECTOR | 7403 York Road | | | | - | wson | | | | | Dait. | | |
| physician. burial-transit permit. Pages | DIRE | Maryland Balt | ' imore Co | unty | | WSON | | TION | | | | | | d. INSIDE CITY LIMITS? YES 2 XNO |
| med : | 3AL | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | | | | _ | | T COUNTRY? |
| ian. transit | FUNERAL | 7403 York Road | 12. WAS DECEDE | NT EVER IN | 21 20 4 N U.S. ARMED 13. WAS DECENDENT OF HISP. | | | | | C ORIGIN? (S | nacity Yas | | U.S.A | American Indian. |
| ding physic the burial | B | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? IF YES, GIVE | 1 YES | 2 NO | O If yes, specify Cuban, Mexican, Puerto Rican, atc.) 1 YES 2 NO Specify: | | | | | | Black, White, etc. Specify: White | | |
| attenuse as | LED | 15. DECEDENT'S EDU (Specify only highest grade | | | 16a. DECEOENT'S (Give kind of life. Do NOT u | Work done | CCUPATIO | ON ast of worldn | ng | 16b. KJA | D OF BUS | INESS/INDUS | STRY | |
| ched for | COMPLET | Elementary/Secondary (0-12) 12 years | College (1-4 or 5 | i+) | Homema | | | | | | | | | |
| retained by the hospital or attending 5 should be detached for use as the nettified at once. | BE CO | 17. FATHER'S NAME (First, Middle, Lest) Everett Grant Ja | rvis | | | | | Id | a Ma | e Seat | old | | | |
| 5 should | 2 | 19a. INFORMANT'S NAME (Type/Print) | . 1 | | | | • | | | | | n, State, Zip C | | |
| page page | | Dr. John E. Mark | | 20b. | PLACE OF DISPO | | | | | ore, r | | and 2 | | Stata |
| e 6 ma ector, p | | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | oval from State | _ Du1 | aney Va | lley | Мел | noria | 1 Ga | rdens | Lut | hervi | 11e, | Maryland |
| death. Pag tuneral dir i. examiner | | 21. SIGNATURE OF FUNERAL SERVICE LI | 1-0 | 9.A | 77- | | | ho ADDRE | | urv defelo | I Hom | | | |
| irs after death. Page 6 may be n by the funeral director, page removal. edical examiner must be | | ▶ John G. Rei | tz | 10 11 | | | 6500 | Yor | k Rd | ., Bal | timo | re, M | aryla | and 21212 |
| filled ion, or the m | | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Me | tax | | Col | ^ | | | | | ratory erret | it, | Approximets Interval Betwee Onset end Deat |
| th certificate be execuending physician and Hygiene prior to bur or other traumati | CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | | CONSEQUENCE (| | | | | | | | | |
| w requires that the deat been signed by the atti pt, of Health and Merita shows any injury, | MEDICAL C | PART II. Other significent condition | ns contributing t | to deeth be | ut not resulting | In the u | nderlyln | ng ceuse | given in | | WAS AN PERFOR YES 2 | RMED? | AM CC | ERE AUTOPSY FINDING WAILABLE PRIDE TO OMPLETION OF CAUSE F OEATH? |
| requires een sign of Heal | | | | | | | | | | _ | | | 11 | YES 2 DO |
| has be Dept. | AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. P | LACE OF D | DEATH (Ch | ck only one) | | | | |
| SICIAN: The law certificate has I in the State Dept d, or item 23 | SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: | □ ER/Outp | etlent 3 🗆 DOA | OTHE | R: | 0 | | 6 Other (S | pecify) | | | |
| this certif with the ted, or | PHYSICIA | 27. MANNER OF DEATH | 26a. DATE ((Month, | DE INJURY | 26b. Ti | ME OF | | JURY AT ORK? | | 28d. OEŞCR | IBE HOW I | NJURY OCCU | JRED | |
| DING PHYS After this of death with | BY | 1 Netural 5 Pending 2 Accident Investigation | 280 DI ACE | OF IN BIOV | Al barra form | M steed 4s | | YES 2 | NO | 201 1 0 0 1 7 | DBI /Pamer | and Mumbas a | Pumi Pou | sha Alizanbar |
| OR ATTENDING DIRECTOR: After hours after death tom 28 Is ma | TED | 3 Suicide 6 Could not be 4 Homicide determined | buildin | g, etc. (Spec | — At nome, farm | m, street, factory, office 28f. LOCATION (Street and Number or Rural Route N City or Yown, State) | | | | | le Number, | | | |
| AL OR A AL DIREC 72 hours 11 item | COMPLET | 29a. CERTIFIER (Check only | SICIAN: To the best | of my knowl | ledga, death occu | rred at the | time, dat | a and place | e, and dua | to the cause | (a) and me | nner as atate | d. | |
| HOSPITAL FUNERAL within 72 | CON | one) 2 MEDICAL EXAMIN | | axamination | n and/or investige | tion, in my | opinion, | | | | d place, a | nd due to the | cause(a) e | nd manner as stated. |
| TO THE HOSPIT TO THE FUNERA be filed within 7 | BE | 296. SIGNATURE AND TITLE OF CERTIFIE | 1 Ha | 4 | | | | | 203 | - | | 29d. DATE | SIGNEO (M | fonth, Day, Year) |
| F F Z S | 5 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CA | NUSE OF DE | ATH (ITEM 27) (Tr) | | Ba l | 11 | m | _ | 23 | 5 | | |
| 100 | | 31. DATE FILED (Month, Day, Year) | 32. REGIST | BAR'S PIGN | AJURE HON | LE | | | , _ | |) | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.





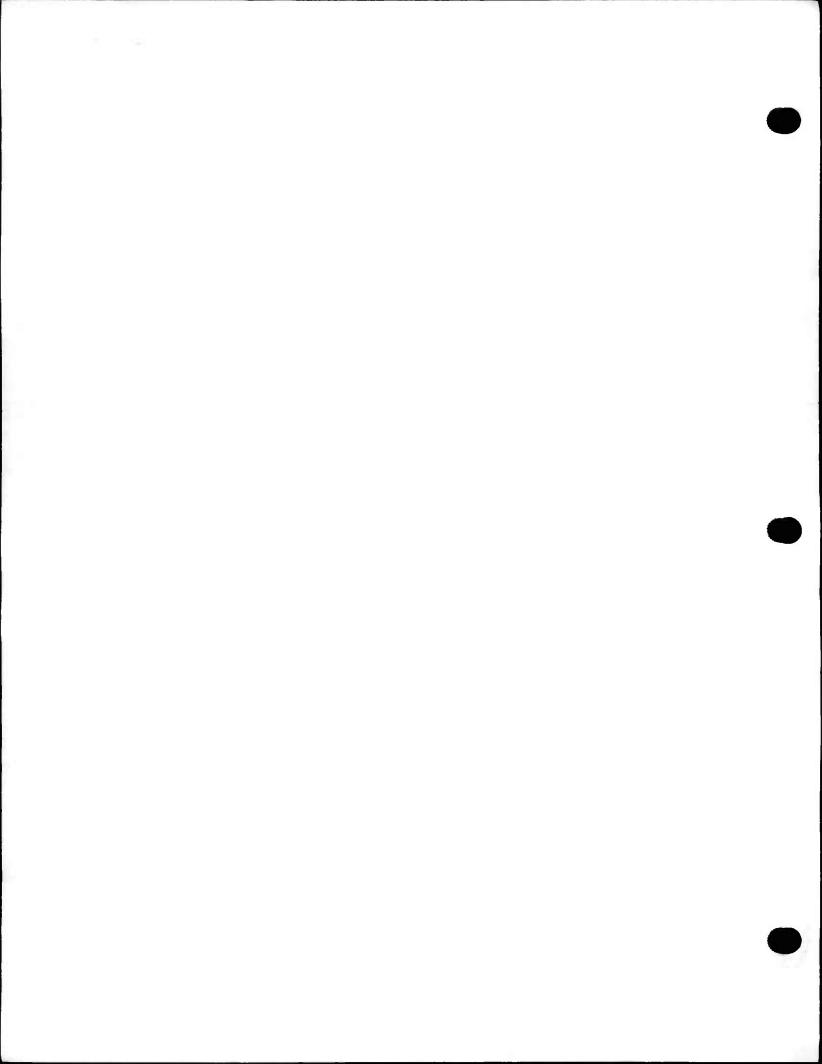
| | | | | | | | • | | |
|---------------------|---|--------------------------------------|--|---------------|------------------|---------------------------------|---|----------------|--|
| | FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF HEALT | | | GIENE G. NO. | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | MCC | le spho | I. McCle | | DATE OF DE | DAY O | YEAR 3. | 11ME OF DEATH 9:45 Pm |
| | 164-26-2922 | 1 M 2 D F | 8 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 32 Cou | | | | | Country) | CE (State or Foreign |
| OR | 90. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH 90. CITY, TOWN OR LOCATION OF DEATH Baltimore RESIDENCE OF DECEDENT | | | | | | | | |
| BY FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CIDY, TOWN OR LOCATION BOLL IMOR | | | e City | | | 1. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | zona x | Ive, | 101. ZIP C | ODE 1206 | , | | en of what | country? |
| | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER I FORCES? 1 X YES IF YES, GIVE WAR OR D WAR OR D | | 2 ☐NO If yes, specify Cuben, Mexicen, Pue 1 ☐ YES 2 ☑ NO Specify: | | | ORIGIN? (Spe Puerto Ricen, e | RIGIN? (Specify Yee or No- erto Ricen, etc.) 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4 or 5 +) | | 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | 16b. KIND | Bb. KIND OF BUSINESS/INDUSTRY | | |
| MPL | 12 | | Police Officer | | | | Baltimore City | | |
| BE CC | 17. FATHER'S NAME (First, Middle, Leat) George B. McClellan 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | 5 | | |
| 임 | Janis McClellan 6025 Arizona Ave. Baltimore, Maryland 21 | | | | | | 206 | | |
| | 20s. METHOD OF DISPOSITION 1XI Burlel 2 Cremetion 3 Ramovat from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Freeland Cemetery 12/12/90 Freeland Freeland | | | | | | | state enna. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MILTON J WIGHT Jr. 22. NAME AND ADDRESS OF FACILITY 21214 | | | | | | | | |
| | Leonard J. Ruck, Inc. 5305 Harford Rd. 23. PART I. Enter the disease, dr. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate Approximate | | | | | | | | |
| | shock, or heart fellure. L IMMEDIATE CAUSE (Fine) disease or condition | let only one sause on a | ach line. | | | | r reepiretory erro | et, | Approximete Interval Between Onset and Death |
| | resulting in deeth) | | | Hyrans | | | | | 2 > 1 = 1 |
| ATION | Sequentially list conditions, if any, leading to immediate cause, Enter UNDERLYING | STITAL FIBROSIX of TITE LUNGS 27 EAR | | | | | | 2 YEARS | |
| CERTIFICATION | CAUSE (Disease or Injury that initieted evente resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | |
| | DART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| PHYSICIAN: MEDICAL | | | | | | | PERFORMED? 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | MPLETION OF CAUSE DEATH? |
| AN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26 BI ACE C | NE DEATH (Charle | anti ana) | | | |
| YSICI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26b. TIME (| | | | | | | |
| | 2 Accident 3 Suicide 4 Homicide 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | e Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the best of examination and/or investigation, in my opinion, death occurs at the time, date end place, and due to the cause(e) end menner as stated. | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER PT STOR | L'NT | 7HYS70 | 29c. | LICENSE NUMBE | ER > | | SIGNED (M | onth, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | | | 0 | | | | |

32. REGISTRAR'S SIGNATURE



BALTIMORE

HOSPIGAL



TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24-mours after death, Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE | 0F | MARYLAND / | DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIEN | ΙE |
|-------|----|------------|-------------------|----|---------------|-----|---------------|---------|----|
| | | CE | RTIFICATE | 0 | F DEAT | TH | | REG. NO |). |

| I - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 90 34037 | | | | | | | | | |
|--|--|---|--|---|---------------------|--|--|--|--|
| * 1 | ERINE E. MALL | ONEE | | 2. DATE OF DEATH DAY | | 3. TIME OF DEATH | | | |
| 7. T-20-20- 10-02 | SEX 6. AGE (In yrs. 1 | YRS. MONTHS | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. Y, TOWN OR LOCATION OF DE | 7. DATE OF BIRTH (Month, Day, Vear) 03 13 39 | Cour | MARYLAND | | | |
| 2918 KESWICK ROAL | | 96. 01 | BALTIMORE | EAIH | 9C. COUNTY OF | DEATH | | | |
| 10s. STATE 10b. COUNTY MARYLAND | | 10c. CITY, TOWN | OR LOCATION TIMORE | | | 10d. INSIDE CITY LIMITS? Ty YES 2 \(\square\) NO | | | |
| 100. STREET AND NUMBER 2918 K | ESWICK ROAD | | 10f. ZIP CODE 21211 | | 10g. CITIZEN OF USA | WHAT COUNTRY? | | | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 1 Proced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year of Yes, specify Cuben, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | | | CE — Americen Indian, lok, White, atc. potty: WHITE | | | |
| 15. DECEDENT'S EDUCATII (Specify only highest grade com Elementary/Secondary (0-12) C 12TH | pleted) | DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired. HOUSEW | during most of working) | 16b. KIND OF BUSI | INESS/INDUSTRY | | | | |
| 17. FATHER'S NAME (First, Middle, Lest) CARROLL WAGNER | | | F | ME (First, Middle, Malden S RANCES KOWA | ALSKI | | | | |
| 194. INFORMANT'S NAME (Type/Print) DONALD MALLONEE | | | SS (Street and Number or Rural WICK ROAD, B | | MD • | 21211 | | | |
| 20e. METHOD OF DISPOSITION 1 \$\overline{\text{S}}\$ Buriel 2 \(\text{Cremetton} \) Cremetton 3 \(\text{Removal} \) Removal 4 \(\text{Donatton} \) Donatton 5 \(\text{Other} \) Other (Specily) | LTIMORE | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211 | | | | | | | | | |
| ahock, pr heert feliure. List iMMEDIATE CAUSE (Finel disease pr condition reculting in death) Sequentielly list conditions, if any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted events | 23. PART I. Enter the diseasea, pr complicatione that caused the deeth. Do not anter the mode of dying, such as cardiac or reapiratory errest, ahock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. BREAST CANCER BRAIN METASTASES 1 yes 2 No | | | | | | | | | |
| | OSPITAL: Inpatient 2 ER/Outpetient 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 6 Other (Specify) 28d. DESCRIBE HOW IN | | | | | |
| 3 Suicide 6 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY — At building, etc. (Specify) | nome, term, street, fo | клогу, описе | 281. LOCATION (Street a City or Town, State) | na number or Huri | ni rioute Number, | | | |
| (Check brilly | N: To the best of my knowledge, On the basis of extendingstion and/ | | | s time, data and place, and | d due to the caus | e(a) and manner as stated. ED (Month, Day, Year) | | | |
| 30. NAME AND ADDRESS OF PERSON WHO CO SAMUEL ZY 6 31. DATE FILED (Month, Day, Yoar) DEC 11 1990 July | OMPLETED CAUSE OF DEATH (1) 32 JEGISTHAR'S AGNATURA | ITEM 27) (Type, Print) | 10356 10 COVE | 5 RO | BAT | 17/90 NO 21200 | | | |





FOR

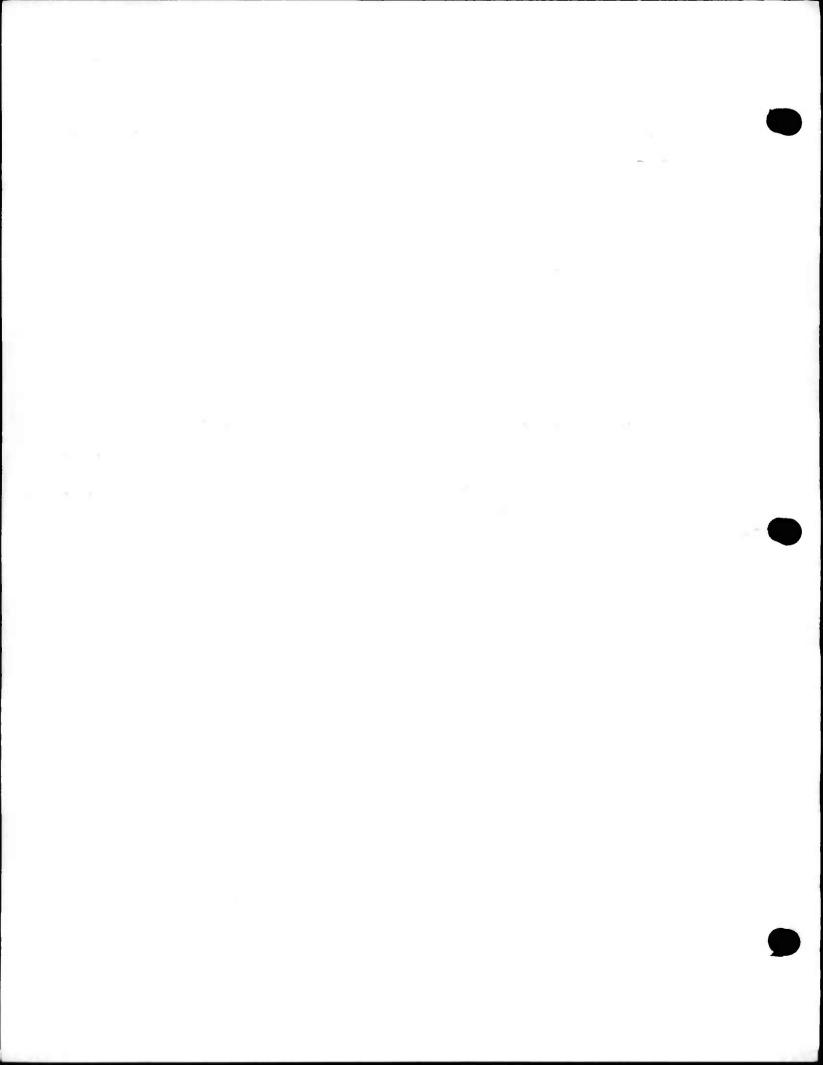
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| ther death. Page 6 may be retained by the hospital or attending physician. | the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s oval. | al examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|---|--|--|---|
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a wours after death. Page 6 may be retained by the hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 s fied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | CERTIFIC | CATE O | F DEATH | | REG. NO. | | | |
|---|---|-------------------------------------|-------------------------------|-------------------------|----------------|------------------|--------------|------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | F DEATH DAY | | YEAR | 3. TIME OF DEATH |
| GLADYS W | . McCOHA! | 2 | | | MONTH | 2 - | | 90 | 1858 |
| 4. SOCIAL SECUPITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | | | | BIRTH | 8. | . BIRTHE | PLACE (State or Foreign |
| 214-74-1743 | 1 M 2 XF | RO YRS. | IONTHS DAYS | HOURS MIN. | DEC. | 22,190 | 00 | MD. | |
| Da. FACILITY NAME (If not institution, give str | reet and number) | 89 | 9b. CITY, TOW | N OR LOCATION OF DE | | | 9c. COUNT | Y OF DE | ATH |
| SHADY GROVE ADV | ENTIST HOSP | | ROCK | VILLE | | - 1 | MOI | NTGC | MERY |
| RESIDENCE OF DECEDENT | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | |
| Da. STATE 10b. COUNTY | | 1 | TOWN OR LO | | | | | | 10d. INSIDE CITY LIMITS? |
| MD. MONTO | OMERY | | GAITHE | RSBURG | | | | | 1 XYES 2 NO |
| De. STREET AND NUMBER | | | | 10f. ZIP CODE | | | 10g. CITIZE | N OF W | HAT COUNTRY? |
| 211 Russell Ave. | | | | 20877 | • | | 1 | USA | |
| 1. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED | | ECENOENT OF HISPAN | | | or No— 1 | 4. RACE | - American Indien, White, etc. |
| Naver Married 2 Married Wildowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | | ES 2 NO Specifi | | can, atc.) | - 1 | Specifi | v: |
| Α Ι | | | | | | | | | WHITE |
| 15. DECEDENT'S EDUC (Specify only highest grade | ATION completed) | (Give kind of wo | SUAL OCCUPA rk done during | TION most of working | 18b. K | UND OF BUSI | NESS/INDUS | STRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use | retired.) | | | | | | |
| 12 | 0 | HOMEMAK | ER | | | HC |)ME | | |
| FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Mic | ddle, Maiden S | umame) | | |
| EDWARD MONROE | WHALEY | | | LILLI | AN | MA | Z W. | ILSC | ON |
| a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING / | ADDRESS (Street | et and Number or Rural | Route Number | r, City or Town, | State, Zip C | ode) | |
| JAMES A. McCOMAS, | JR. | 4408 ST | UART A | VE. RIC | HMOND | ,VA. | 232 | 21 | |
| a. METHOD OF DISPOSITION | 20 | b. PLACE OF DISPOSI other place) | TION (Name of | cemetery, crematory or | | 20c. LOC | ATION — CI | ty or Tov | vn, State |
| Surial 2 □ Cremation 3 □ Ramo □ Constion 5 □ Other (Specify) | | | LLEY | MEMORIAL | GARDE | NS CO | CKEY | SVII | LLE. MD. |
| . SIGNATURE OF FUNERAL SERVICE LIC | | | 22. NAME | AND ADDRESS OF FA | CILITY | | | | |
| · mullilla | 1 2 1 | 1. / | | EIEL H. BA | | | | | |
| " foreign | -/DAL | 11/ | | | | | | | ILLE,MD.20 |
| 23. PART i. Enter the diseases, or o shock, or heart failure. | | | t enter tha | mode of dying, suc | h ss cardle | ac or respin | atory erres | Bt, | Approximate Interval Between |
| MMEDIATE CAUSE (Finel | | | | | | | | | Onset and Des |
| disease or condition resulting in death) | Bupture DUE TO (OR AS | of thorac | ic a 01 | rtic Aneni | rysm | | | | minutes |
| | | | | | -/- | | | | minutes years |
| | DUE TO (OR AS | ignestinaion | | | | | | | years |
| Sequentially list conditions, if eny, leading to immediate | DUE TO (OR AS | CONSEQUENCE OF) | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury | C | | | | | | | | |
| that initiated eventa | DUE TO (OR AS | A CONSEQUENCE OF) | : | | | | | | |
| resulting in death) LAST | d. | | | | | | | | - |
| APT II Oat and a Maria | | | | | | | 4 414 | | T . |
| PART II. Other significant condition | | but not reaulting in | the underly | ing ceuse given in | Part i. | PERFORI | | 24b. | WERE AUTOPSY FINDING AMAILABLE PRIOR TO |
| Chronic hyperpar | Myrodian | | _ | | 1 | 1 _ YES 2 | NO NO | | COMPLETION OF CAUSE OF GEATH? |
| | | | | | | | | | 1 TES 2 NO |
| | | | | | | | | | |
| 5. WAS CASE REFERRED TO MEDICAL | | | 26 | PLACE OF DEATH (C) | heck only one, |) | | | |
| EXAMINER? 1 YES 2 NO | HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Out | | OTHER: | Ioma 5 🗆 Realdence | 8 🗆 Other | (Specify) | | | |
| 7. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c. | INJURY AT | | RIBE HOW IN | JURY OCCU | JRED | |
| 1 Natural 5 Pending | (Month, Day, Year) | INJU | | WORK? YES 2 NO | | | | | |
| 2 Accident Investigation | 28a, PLACE OF INJUR | Y — Al home, farm, st | | | 28f LOCA | TION (Street as | nd Number o | or Rugal F | loute Number |
| 3 Suicide 8 Could not be determined 28a. PLACE OF INJURY — Al home, farm, street, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| 9a. CERTIFIER | | | | | | | | | |
| (Check only | CIAN: To the best of my know | | | | | | | | |
| one) 2 MEDICAL EXAMINE | R: On the basis of examination | on and/or investigation | , in my opinio | n, death occured at the | e time, data a | and place, end | dua to the | cause(a |) and manner as stated. |
| 96. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NU | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| Byl O. Johnson | mD. | | | 0-190 | 42 | | ► 12 | -141 | 90 |
| 0. NAME AND ADDRESS OF PERSON WH | O COMPLETEO CAUSE OF D | EATH (ITEM 27) (Type. | Print) | 1 | · | | | 1 1 | |
| BYRL O. JOHNS | | issell Aven | ine 6 | raithers bn | 19, M | Lykna | 20 | 179 | |
| 1. DATE FILED (Month, Day, Year) | | NATION | | | . L * | | | | |
| DEC 1 1 1990 | 32 REGISTRAR'S SIG | - Mandall | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2ours after death. Page 6 may be retained by the host | tache | Ç. |
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| | C . | = = |
| 2 | TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to bring in managing or named. | the med within 12 flows are used with the base been, or need any injury, or other traumatic event, the medical examiner must be notified at once. |

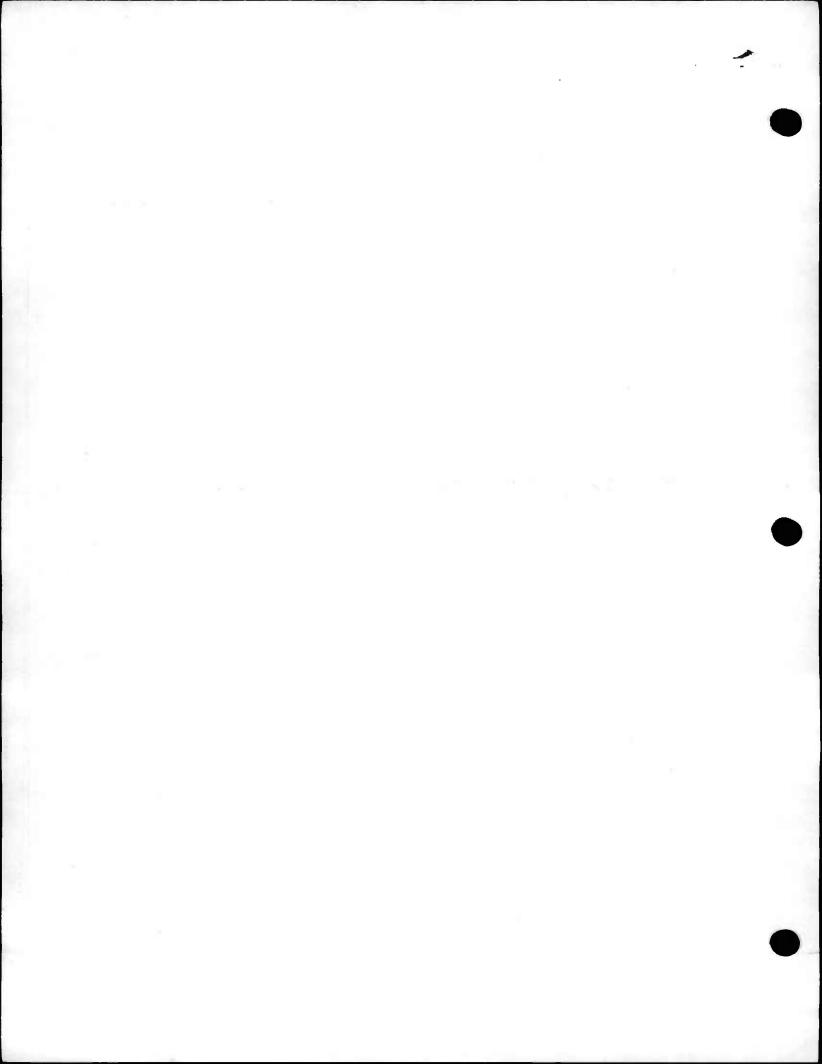
31. DATE FILED (MONTH, Day, Your)

NFC 11 1990

| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N | MENTAL HY | GIENE | 34035 | | | | | | |
|-------------------|--|------------------------|------------------------------|--|--|--|--|--|--|--|
| | 1 - STATE CERTIFICATE OF DEATH | | G. NO. | | | | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) JOHN (NMN) MACK | 2. OATE OF DE MONTH | DAY | 3. TIME OF DEATH 7:19 a.m. M | | | | | | |
| Ť | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 MRS. | 7. DATE OF BI | RTH | B. BIRTHPLACE (State or Foreign | | | | | | |
| | 212-24-9975 1 M 2 F 63 YRS. MONTHS DAYS HOURS MIN. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE | | , 1927 | Maryland | | | | | | |
| DR | NORTH ARUNDEL HOSPITAL ASSOCIATION GLEN BURNIE | Salli | 20 27 | E ARUNDEL. | | | | | | |
| 5 | RESIDENCE OF DECEDENT | | ZIIII | G "WKONDED. | | | | | | |
| DIRECTOR | Md. Anne Arundel Pasadena | | | 10d. INSIDE CITY LIMITS? 1 YES 2 ANO | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 107. ZIP CODE 21122 | | | EN OF WHAT COUNTRY? | | | | | | |
| ž | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPAN | IIC ORIGIN? (So | | 14. RACE — American Indian, | | | | | | |
| BY FL | 1 Never Married 2 Married FORCES? 1 Never Married FORCES? 1 Never Married If yes, specify Cuben, Mexica 1 yes, specify Cuben, Mexica 1 yes 2 No Specify Cuben, Mexica 1 yes 3 No Specify Cuben, Mexica 1 yes 4 No Specify Cuben, Mexica 1 yes 4 No Specify Cuben, Mexica 1 yes 5 No Sp | n, Puerto Rican, | atc.) | Black, White, etc. Specify: White | | | | | | |
| Q | 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION | 16b. KIND | OF BUSINESS/INDU | | | | | | | |
| ET | (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Give kind of work done during most of working life. Do NOT use retired.) | 1000 7000 | | | | | | | | |
| PL | 10 None Self Employed | Au | to Parts | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NA | | | | | | | | | |
| BE C | Charles Mack Unknown | n | | | | | | | | |
| | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural I | | ty or Town, State, Zip (| Code) | | | | | | |
| 5 | ELIZABETH MACK Same As 10 | | | | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Paurisi 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetary, crematory or other place) | | 20c. LOCATION — C | Ity or Town, State | | | | | | |
| | 4 Donation 5 Option (Specify) Glen Haven Memorial Park Glen Burnie, Md. | | | | | | | | | |
| | 21. SIGNATURE OF FINERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home | | | | | | | | | |
| | 1 Second Ave | | | ie.Md. 21061 | | | | | | |
| | 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, suc | | | | | | | | | |
| | ahock, or haart failura. List only one cause on each line. | rr du Cardiac C | or respiratory arre | interval Batween | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | | | Onset and Death | | | | | | |
| | resulting in death) a. DUE TO (OR AS A CONSPONENCE OF) | | | 2 Kans | | | | | | |
| - | disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): UNG ON CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | 3 years | | | | | | |
| CERTIFICATION | Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): | | | 179011175 | | | | | | |
| ¥. | cause. Enter UNDERLYING | | | | | | | | | |
| F | CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| H | resulting in death) LAST | | | | | | | | | |
| | | | | | | | | | | |
| Ä | PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in | Part I. 24s. | WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO | | | | | | |
| Ď | | 1 🗆 | YE\$ 2 NO | OF DEATH? | | | | | | |
| M | | | | 1 TES 2 NO | | | | | | |
| PHYSICIAN: MEDICA | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | eck only one) | | | | | | | | |
| YSI | 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence | 6 Other (Spe | raffy) | | | | | | | |
| | 27. MANNER OF OEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 Ves 2 NO | 28d. DESCRIB | E HOW INJURY OCC | URED | | | | | | |
|) BY | 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office | | | or Rural Route Number, | | | | | | |
| TEL | 4 Homicide datermined building, etc. (Specify) | City or Tow | vn, Stere) | | | | | | | |
| Z | 29a. CERTIFIER (Check only) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due | to the cause/s) | and manner on state | od. | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the | | | | | | | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER () 29c. LICENSE NUI | MBER | 29d. DATE | SIGNED (Month, Des Mar) | | | | | | |
| TO B | Janes J. W. My Car D32. | 215 | 1 | 2/7/20 | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OFATH (ITEM 27) (Since Print) | | | 1 1 | | | | | | |

M. D. /7706 QUATERFIELD ROAD/CLEN BURNIE,

DHMH-15 Rev 1/89



| 1 | 05 | 53 | 705- | 0340 | 4.50 |
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| 粉 | CH | OR | RIS | BOY-B | JOANN |
| | | | 150 | \$1 | |

| | | | 15/0 | 7/90 S | 1 | | | | | |
|--|--|---|----------------------|--|---------------|---|--|--|--|--|
| 1 - FOR STATE (| OF MARYLAND / DEPART CERTIFIC | MENT OF HE | ALTH AND M | ENTAL HYGIEN | 90 | 34040 | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH DATE OF DEATH | AY YE | 3. TIME OF DEATH | | | | |
| Baby Boy McMorris | (Ellis) | | 300 | 12 7 | | 990 0230 M | | | | |
| 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birthday) | | IF UNDER 24 HRS. | 7. OATE OF BIRTH (Month, Day, Year) | 6. E | BIRTHPLACE (State or Foreign country) | | | | |
| 9e. FACILITY NAME (If not institution, give street and numb | 97) | 9b. CITY, TOWN OR | 2 10 LOCATION OF DEA | 12 7 19 | 90 Sc. COUNTY | Baltimore OF DEATH | | | | |
| Sinai hospital of I | Baltimore | Baltimo | ore | | | Maryland | | | | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | |
| Mary and | | 101. 2 | IP CODE | | 10g. CITIZEN | 1 YES 2 NO OF WHAT COUNTRY? | | | | |
| 1606 DARTFORD ROAD | _ | | 21221 | _ | τ | JSA | | | | |
| 1 Never Married 2 Married FORCES | CEDENT EVER IN U.S. ARMEO 7 1 TYES 2 TO NO RIVE WAR OR DATES | Il yee, spec | | C ORIGIN? (Specify Ye, Puerto Ricen, etc.) | | RACE — American Indian, Black, White, etc. Specify: BLACK | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4) | (Give kind of we | USUAL OCCUPATION ork done during most a retired.) | of working | 18b. KIND OF BU | SINESS/INDUST | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | /- T | 18. MOTNER'S NAM | NE (First, Middle, Maiden | Sumame) | | | | | |
| ANTHONY ELLIS 190. INFORMANT'S NAME (Type/Print) | 10h MAHINO | | JOANN | McMORR. | IS | va) | | | | |
| 196. INFORMANT'S NAME (Type/Print) 19b. MAILINO ADDRESS (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 4411 WAKEFIELD RD BALTIMORE, MD 2 | | | | | | | | | | |
| 20e. METNOD OF DISPOSITION 1 XBuriel 2 Cremation 3 Removal from Sta 4 Donetion 8 Other (Specify) | 20b. PLACE OF DISPOSE other place) WESTERN | | | | CATION — City | or Town, State | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | WESTERN | | ADDRESS OF FAC | | LONDAT | ппк, но | | | | |
| LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207 | | | | | | | | | | |
| 23. PART-1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Dasth | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST D. Presumed complex congenital heart disease DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| PART II. Other algnificent conditions contributi | ng to death but not resulting in | in the underlying | cause given in l | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO | | | | |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER HOSPITA | | OTHER: | CE OF DEATH (Che | | | | | | | |
| | nt 2 ER/Outpatient 3 DOA | 4 Nursing Nome | | | MINUTE ASSE | F0 | | | | |
| 1 Natural 5 Pending (M | ATE OF INJURY 28b. TIME onth, Day, Year) INJU | URY WOR | | 28d. DESCRIBE NOW | INJUNY OCCUR | EU | | | | |
| | ACE OF INJURY — At home, farm, s | street, factory, office | | 281. LOCATION (Street City or Town, State | | Rural Route Number, | | | | |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN: To the bar one) 2 MEDICAL EXAMINER: On the bar | | | | | | euse(e) end manner ee atated. | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | / ^ | | 29c. LIÇENSE NUN | IBER | 29d. DATE S | IGNED (Month, Day, Year) | | | | |
| X alplan An | Trus Me | D 23751 | | | 751 12 7 | | | | | |
| 30. MAMM AND ADDRESS OF PERSON WHO COMPLETE Kathleen Stevensm M.D. | and the second second | | timore | | | | | | | |
| Kathleen Stevensm M. D 31. DATE FILED (Month, Day, Year) 32. RE DFC 1 1 1990 Julia | GISTRAN'S SIGNATURE | n Dal | | | | | | | | |
| DFC 1 1 1990 guha | war access-Nativara | | | | | | | | | |



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| | _ | | REGISTRAR | | CE | :RHFK | CALE | F DEATH | RE | G. NO. | | |
|--------------|--|---------------|---|---|-------------------------|---|------------------------------|--------------------------|---------------------------------------|-----------------------------|--------------------------|--|
| | | | 1, DECEDENT'S NAME (First, Middle, Last) | JOHN WERN | ER MAI | ROUSE | SE | | 2. DATE OF DE | DAY 05 | YEAR GO | 3. TIME OF DEATH 3:00 Pm |
| | _ | | 4. SOCIAL SECURITY NUMBER 216-12-8944 | 5. SEX 6. AG | \$3 last | | IF UNDER 1 YEA | | 7. DATE OF BIF (Month, Day, 9/1 | | Countr | IPLACE (State or Foreign ry) FRMANY |
| 0 | 3 should | ~ | 9a, FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TOW | N OR LOCATION OF DE | ATH | | OUNTY OF D | EATH |
| | | DIRECTOR | SINAI HOSPITAL | | | | | BALTIMO | RE | | | |
| .5 | Pages 1, 2, | E I | 10e. STATE 10b. COUNTY | 1 | | 10c. CITY, | TOWN OR LO | | | | | 10d. INSIDE CITY LIMITS? |
| - | 1 | . 10 | MARYLAND | | | | BAI | TIMORE | | | | 1 YES 2 NO |
| 1. | To ano | FUNERAL | 2508 TANEY RD. | | | | | 10f. ZIP CODE 212 | 09 | 10g. C | USA | WHAT COUNTRY? |
| \ \ | To a | BY FUR | 11. MARITAL STATUS 1 | 12. WAS DECEDENT EVE FORCES? 1 YI IF YES, GIVE WAR OF | ES 2 X | 2 NO If yes, specify Cuben, Mexican, Puerto | | | | ecify Yee or No- etc.) | 14. RACI Blac Spec | E — American Indian, ik, White, etc. WHITE |
| | 88 | 8 | 15. DECEDENT'S EDU | | | | SUAL OCCUP | | 16b. KIND | OF BUSINESS/I | INDUSTRY | |
| COZI | or use | | (Specify only highest grade Elementery/Secondary (0-12) | College (1-4 or 5+) | (Gi | ve kind of wo Do NOT use | ork done during retired.) | most of working | | | | |
| LAND A | detached f | COMPL | | 5+ | | AT | TORNE | Z | | AT I | LAW | |
| 7 4 | detach | | 17. FATHER'S NAME (First, Middle, Last) | | _ | 16. MOTHER'S NAME (First, Middle, Melden Surneme) | | | | | | |
| | should be | 8 | BERNHAI 190. INFORMANT'S NAME (Type/Print) | RD MARCUS | | MAILING A | ANNESS (Str. | eet and Number or Rural | MARTHA | | AELIS | ····· |
| MARI | 9 10 | 2 | MRS. LESLIE MARC | USE | | | | CHWOOD RD. | | GE PARI | . , | 20&40 |
| ביים | page page | | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem | | 20b. PLACE (| OF DISPOSE | | f cemetery, crematory or | | 20c. LOCATION | | |
| Page 6. | Ect ect | | 4 Donetlen 5 D Other (Specify) | | | | | CHESED | | RANDAI | LLSTO | WN, MD |
| 4 G | e funeral din | | 21. SIGNATURE OF FUNERAL SERVICE LIK | CENSEE | | | | E AND ADDRESS OF FA | | ., INC | • | |
| offer death | 9 2 8 | | > Jay (Way | Lun | | | | O REISTERS | | | 10.,M | D 21215 |
| of bours of | or re | | 23. PART Enter/the diseases, or shock, or heart failure. | List only one cause or | n eech line | ·- | | | | r reepiratory | erreet, | Approximate Interval Between Onset and Death |
| shin 2 | pletely fille cremation. | | disease or condition resulting in death) | . RES | PIR | ATO | RY | FAILU | RE | | | ONE |
| 13140, | B 5 - 6 | | _ | | | | | HEZIRT | | (110 | T | MONTH |
| | and to bur | CERTIFICATION | Sequentielly list conditions, if any, leading to immediate | DUE TO (OR A | S A CONSEC | QUENCE OF | V = 1 | TETRI | + 7 | CCCE | | |
| 2 2 | nysicia prior r trau | CAI | cause, Enter UNDERLYING CAUSE (Diseesa or injury | | EUL | | | | | | | |
| 1 | ing pthy giene | | that initieted events resulting in deeth) LAST | DUE TO (OR A | AS A CONSEC | QUENCE OF) |): | | | | | |
| . { | the attend Mental Hy Nury, or | SER | | d, | | | | | | | | - |
| HUS, F.O. BO | by the atternation of injury, | | PART II. Other eignificant condition | | | - | -77 | | | WAS AN AUTOPS PERFORMED? | SY 241 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ב כ | signed by Health an | EDICAL | SEVERE | 44. | | | | UCTIVE | 10 | YES 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| ביי ביי | been sign of Hea | 2 | PULMON | They D | 156 | NJE | | | _ | / | | 1 - YES 2 - 10 |
| | icate has been State Dept. of Item 23 sho | AN | 25. WAS CASE REFERRED TO MEDICAL | T | | | 2 | 6. PLACE OF DEATH (C) | ank only one) | | | |
| ¥ 1 | certificate h the State (| SICI | EXAMINER? | HOSPITAL: | Outpatient 3 | | OTHER: | Home 5 🗆 Residence | 21Tee | offy) | OSP | 1774L SINA |
| OF VIIAL RE | | Y PHYSICIAN: | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJU (Month, Day, Yo | T/A | 28b. TIME INJU | OF 28c | INJURY AT WORK? | | E HOW INJURY | OCCURED | OFISHLTUR |
| NOIS! | DIRECTOR: After hours after death | TED BY | 2 Accident Investigation 3 Suicide S Could not be 4 Homicide detarmined | 28e. PLACE OF INJ building, etc. (| URY — At ho Specify) | | treet, factory, | office | 28f. LOCATION City or Toxe | | nber or Rural | Route Number, |
| - 9 | E E E E | OMPLET | CONSULT OFFIN | SICIAN: To the best of my k | | eth occurre | d at the time, | | | end manner ee | atated. | |
| Š | FUNER Within | 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER: On the basis of examin | anion andor | mweetgecror | n, m my opine | | | | | D (Month, Day, Year) |
| | TO THE FUSPITAL U TO THE FUNERAL D De filed within 72 ho IMPORTANT: If its | TO BE | XINH | THAI | MD | | | beepe | 22 | 2/ | 12 | 15/90 |
| | | | 30. NAME AND ADDRESS OF PERSON W | A COMPLETED CAUSE OF | (NA | 1 21) (Npa, | 405 | PITZIC | OFP | BALT | IM | DRE |
| | | | 31. DATE FIEED (Morth, Day, Year) 1990 | Zuna David | CONT. POS | nds 90 | 1. | | | | | |
| | | | | - | | | | | | | | |

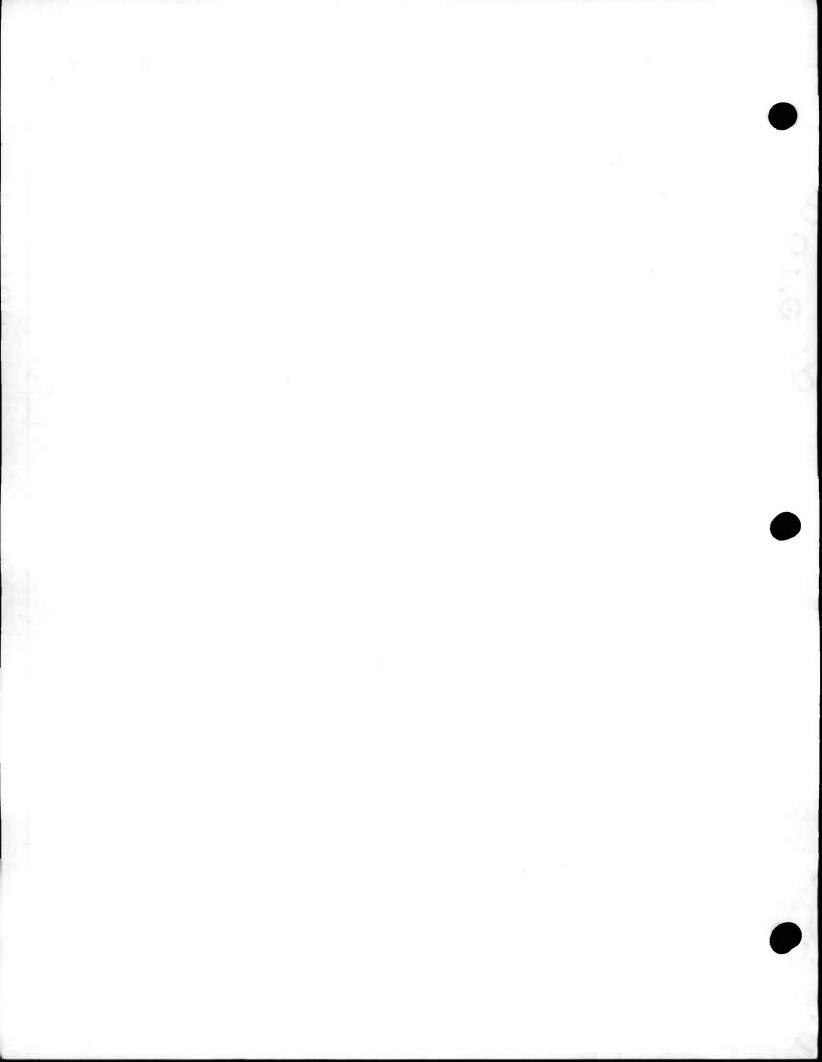
TO THE HOSPITAL DRATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2, nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | |
|---------------|---|---------------------------|--------------------------------|--|---------------|------------|----------------------|-------------|-------------------|--|-----------|-------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | ŋ | | | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| 1 1 | Christi | | Naumann Jr | | | Jr. | | MONT | MONTH DAY 12 7 | | 90 | 8:50P. M | |
| | 4. SOCIAL SECURITY NUMBER | an E. | 8. AGE (In yrs. I | | IF UNDER 1 | | IF UNDER | 24 HRS. | 7. DATE | OF BIRTH | | | IPLACE (State or Foreign |
| | 213-26-7793 | 1 [X] M 2 □ F | 61 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Monti | e 20 1 | 929 | Countr | ryland |
| | 9e. FACILITY NAME (If not institution, give | 01 | | ab CITY 1 | TOWN C | OR LOCATI | ON OF DE | | e 20 i | | | <u> </u> | |
| œ | Section 1995 - March 1999 | | | | | | | | | | | ALPH II | |
| DIRECTOR | Maryland General Hospital Baltimore City | | | | | | | | | | | | |
| l Ä | 10a. STATE 10b. COUN | ITY | | 10c. CIT | Y, TOWN OR | LOCAT | TION | | | | | | 10d. INSIDE CITY LIMITS? |
| 盲 | Maryland E | Baltimore | | | | Car | rney | | | | | | 1 YES 2 NO |
| 4 | 10e. STREET AND NUMBER | | | | | 101 | ZIP COD | _ | | | | | WHAT COUNTRY? |
| BY FUNERAL | 8703 Stockwell | Road | | | | 1 | | | 2123 | 4 | Uni | ted | States |
| 🕺 | 11. MARITAL STATUS | 12. WAS DECEOEN | T EVER IN U.S. / | | | | | | | 1? (Specity Ye Rican, etc.) | or No- | 14. RACI | E — Amaricen Indien, k, White, etc. |
| <u>-</u> | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE V | | JNO | | | 2 X NO | | | rsiceri, etc.) | | Spec | |
| 8 | | I Korean | | | 1 | | | | 1 | | | | wiii ce |
| | 15. DECEDENT'S EG (Specify only highest gra | de completed) | | DECEDENT'S (Give kind of Vite. Do NOT L | work done du | ring mo | ON ost of working | ng | 168 | , KINO OF BU | SINESS/IN | IDUSTRY | |
| 7 | Elementary/Secondery (0-12) | College (1-4 or 5 - 5+ | ·) ' | | ce Wo | wk. | | | | | C & | .D Τ _Δ | lephone |
| COMPLET | 17, FATHER'S NAME (First, Middle, Last) | <u>5</u> ∓ | | OTTI | ce wo | IN | 40 1407 | MED'S NA | ME /Circl | Middle Melder | | 1 10 | терноне |
| | | | | | | | | | | | | | |
| 믦 | 10h MAII INC ADDRESS (Street and Number or Dural Doubl Atturber City or Tourn State. Zin Code) | | | | | | | | | | | | |
| 일 | | | | | | | | | | | d 21234 | | |
| | 200. METHOD OF DISPOSITION 200. PLACE OF DISPOSITION (Name of cametery, cremetory or 200. LOCATION — City or Town, St | | | | | | | | | | | | |
| | 1 M Suited 2 Commetter 2 Permanel from State | | | | | | | | | | Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J Knight Jr. 22. NAME AND ADDRESS OF FACILITY 21214 | | | | | | | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | |
| | Leonard J. Ruck, Inc. 5305 Harford Ro | | | | | | | | | | d Poad | | |
| | 770000 | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ahock, or haart feliure. Liet only one ceuse on each line. Approximate Intervel Between | | | | | | | | | | | | |
| 1 | IMMEDIATE CAUSE (Final | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | | |
| - | | OUE TO | (OR AS A CONS | SEQUENCE (| PF): | | | | | | | | |
| No. | Sequentially list conditions, | b | (OR AS A CONS | SEQUENCE (| DED: | | | | | | · · | | |
| CERTIFICATION | If eny, leading to immediata cause. Enter UNDERLYING | | (on no n cont | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | ,,,, | | | | | | | | |
| 임 | CAUSE (Diseese or Injury that Initiated events | C. DUE TO | (OR AS A CONS | SEOUENCE (| OF): | | | | | | | | |
| E | resulting in death) LAST | ā | | | | | | | | | | | |
| 핑 | | | | | | | | | | | | | |
| DICAL | PART II. Other algoliticant condition | lons contributing to | deeth but no | t resulting | In the unc | dariyin | g cause | given in | Part I. | 24a. WAS A PERFO | N AUTOPS' | Y 241 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | | | | | | 1 TYES | 2 💢 NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | | Inen | ecti | on | 1 - YES 2 - NO |
| ä | | | | | | | | | | 11150 | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSBITAL | | | OTHER | | LACE OF | DEATH (C | heck only o | ne) | | | |
| YS! | 1 YES 2 NO | 1 - Inpetient 2X | | | 4 🗆 Nurs | ing Hor | | esidence | _ | er (Specify) | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. OATE Of (Month, I | F INJURY Day, Year) | 28b. TI | ME OF | W | JURY AT DRK? | _ | 28d. DE | SCRIBE HOW | INJURY O | CCURED | |
| B | 2 Accident investigation | - | | | | | YES 2 | NO | | | | | |
| E | 3 Suicide 8 Could not 4 Homicide determined | pe building | OF INJURY — At, etc. (Specify) | home, ferm, | street, facto | ory, offic | CO | | | CATION (Street or Town, State | | oer or Rural | Route Number, |
| | | | | _ | | | | | <u> </u> | | | | |
| 귤 | Content of the | YSICIAN: To the best o | | | | | | | | | | | |
| COMPL | MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end manner se stated. | | | | | | | | | | | | |
| BE (| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | |
| 6 | 1 | 1 | | | | | | OCM | E | | | 12-8 | 8-90 |
| - | 30. NAME AND ADDRESS OF PERSON | | | | | <u> </u> | ורכם | -0 | MA | 2120 | 1 | | |
| | Ann M. Dixon, | | | 111 Pe | =1III 2) | L., | Dall | ٠٠, | MG. | 2120 | | | |
| | 31. DATE FILED (Month, Day, Year) DFC 11 1990 | | AR'S SIGNATUR | | | | | | | | | | |
| | | 1 /1 | 14 14 Anna Anna 17 (184) | To the last of the | | | | | | | | | |





Jacob

K.

31. DATE FILEO (Month, Day, Year)
DEC 1 1 1990

Felix,

M.D.

| | | | | | | 0.0 | 34043 | | |
|-------------------|--|--|-------------------------------|--|--------------------------------|------------------|---|--|--|
| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTING CERTIFIC | MENT OF HEALTH AND ATE OF DEATH | MENTAL HYGIEN REG. NO. | E 30 | 34043 | | |
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | Y YEA | 3. TIME OF OEATH | | |
| | Baby Girl Nock | Ebonie Zal | kiya Nock | -Yuille | 11 2 | | | | |
| | 4. SOCIAL SECURITY NUMBER 8. | | - T | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. B | IRTHPLACE (State or Foreign | | |
| | None | □ M 2 💽 F | O YRS. | on the days hours will 5 | (Month, Day, Year) 11-27-90 | Ma | aryland | | |
| ~ | 9a. FACILITY NAME (If not institution, give street | CO CONTRACTOR | 1 | b. CITY, TOWH OR LOCATION OF I | DEATH | 9c. COUNTY | | | |
| Ö | Sinai Hospital of | Baltimore | | Baltimore | | Balti | more City | | |
| ច្ឆ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 100 CITY I | OWN OR LOCATION | | | 10d. INSIDE CITY | | |
| DIRECTOR | | ore County | | allstown | LIMITS? | | | | |
| 7 | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| FUNERAL | 3947 Whispering Meadow Dr. | | | 21133 | | USA | USA | | |
| 5 | | 2. WAS DECEDENT EVER IN | | 13. WAS DECENDENT OF HISP | | or No- 14. | RACE — American Indian, Black, White, atc. | | |
| BY F | 1 ⅓ Never Married 2 ☐ Married FORCES? 1 ☐ YES 2 ⅙ NO IF YES, GIVE WAR OR DATES | | | If yes, specify Cuban, Maxican, Puerto Rican, stc.) 1 □ YES 2 ☒ NO Specify: Black Black | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCAT | | 16a. DECEDENT'S US | | 16b. KIND OF BUS | SINESS/INDUST | RY | | |
| | (Specify only highest grade con Elementary/Secondary (0-12) | mpleted) College (1-4 or 5 +) | (Give kind of world) | k done during most of working etired.) | | | | | |
| <u> </u> | N/A | N/A | none | | | | | | |
| Ž | 17. FATHER'S NAME (First, Middle, Last) | N/A | none | 48 MOTHED'S N | AME (First, Middle, Maiden | Cump ma) | | | |
| | Bruce Ellington Yu | ud 11a | | | te Nock | Surname) | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 11116 | Lancardo maso de | | | | | | |
| 임 | Mr. Bruce E. Yuill | 1. | | DDRESS (Street and Number or Rura nispering Mead | | | | | |
| | 20a. METHOD OF DISPOSITION | | | ON (Name of cemetery, crematory or | | CATION - City | | | |
| | 1 🗆 Burlal 2 🛣 Cremation 3 🗆 Remova | I from Stata | other place) | Cremation, Inc | | - | | | |
| - 1 | 4 Donalion 5 Other (Specify) | lecc. | Calluli | 22. NAME AND ADDRESS OF | | steau, | Maryland | | |
| | 21. SIGNATURE OF PUNETAL SERVICE LICEN | - A - | | Loring Byers | Funeral Di | irector | s. Inc. | | |
| | John K Hy | nul | | 8728 Liberty | | | | | |
| | 23. PART I Enter the diseases, or con | nplications that seused | the deeth. Do not | | | | | | |
| | shock, or haert feilure. Lia | it only one could on ea | ich line. | | | | Interval Between Onset and Deeth | | |
| | IMMEDIALE CAUSE (Fillal | | | | | | | | |
| | disease or condition | | | | | | | | |
| _ 1 | Pulmonary Hypotension of the Newborn | | | | | | | | |
| CERTIFICATION | Sequantielly liet conditiona, b | | CONSEQUENCE OF: | OII OI GIE NEWL | OLII | | To Hours | | |
| ΕI | if eny, laading to immadiate cause. Enter UNDERLYING | • | , | rep pneumonia | s sensis | | j | | |
| 윤 | CAUSE (Diseasa or Injury 6 | | CONSEQUENCE OF: | rep pheamonia | a pepara | | | | |
| ĒΙ | that initiated evants resulting in daeth) LAST | • | , | | | | | | |
| 贸 | d | | | | | - 1 | | | |
| | PART II. Other algnificant conditions of | contributing to deeth be | ut not reaulting in | tha undarlying cause given i | n Part I. 24s. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| 2 | | | | | PERFO | | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | |
| | | | | | | | OF DEATH? | | |
| Σ | | | | | - | | I TES 2 DANO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 28. PLACE OF DEATH (| Shoot anti-anal | | | | |
| PHYSICIAN: MEDICA | EXAMINER? | HOSPITAL: | | THER: | | | | | |
| ĭ. | 1 YES 2 2 NO 1: | ☑ Inpetient 2 ☐ ER/Outp | | ☐ Nursing Home 5 ☐ Residence | | | | | |
| 급 | 1 X Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| Y WORK? | 28d. DESCRIBE HOW | INJURY OCCURI | ED | | |
| B≼ | 2 Accident Investigation | | | M 1 YES 2 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homicids datarmined | 28a. PLACE OF INJURY building, atc. (Spec | — At homa, ferm, atn ://y) | m, atrast, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLETED | | | | | | | | | |
| 7 | | AN: To the best of my knowl | ledge, death occurred | at the time, data and place, and d | ue to the cause(s) and me | nner as stated. | | | |
| 8 | onel | On the basis of examination | and/or investigation, | In my opinion, death occured at I | he lime, data and placa, a | nd due to the ca | use(s) and menner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CENTIFIER | 2 / 2 CO | -Director | 29c. LICENSE N | UMBER | 29d, OATE SI | GNEO (Month, Day, Year) | | |
| 品 | and the | Y - 1A / | | Neonatology | D-19284 | N | 27-90 | | |
| 2 | 30 NAME AND ADDRESS OF PERSON WHO | | | | | , TT- | 21-30 | | |

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE Lie Levidson-Randelle

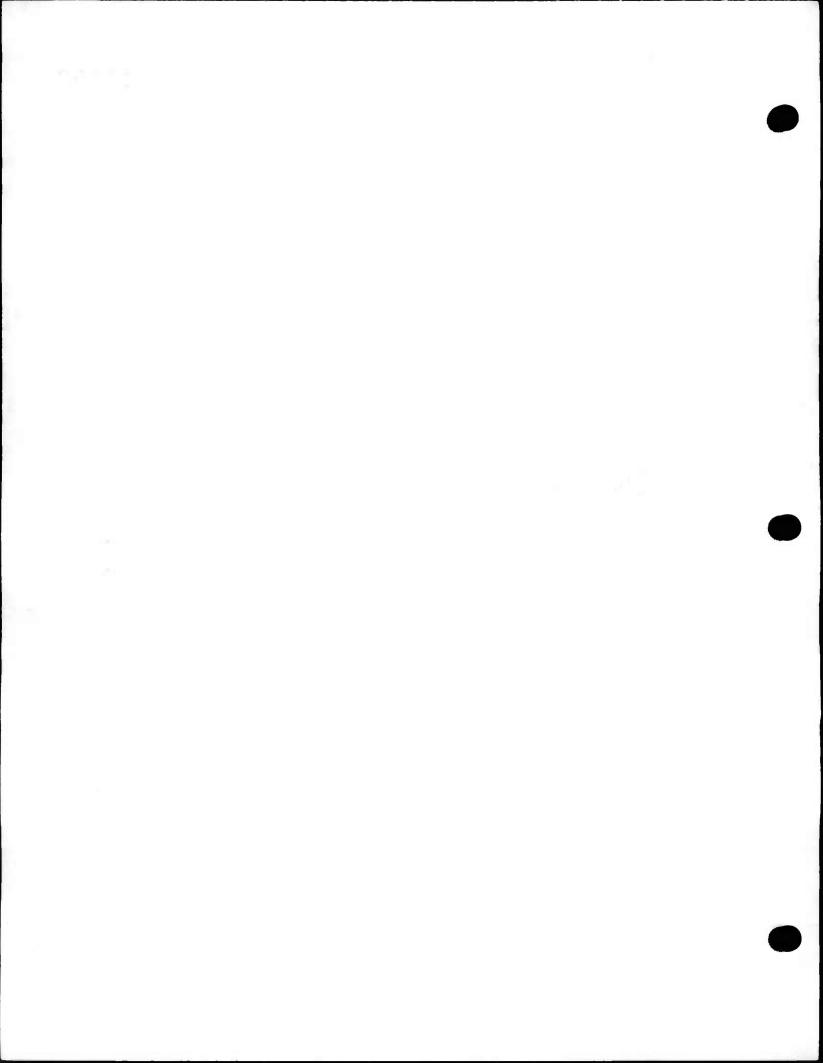
Sinai Hospital of Baltimore,

Baltimore,

21215

Md.

2401 W. Belvedere Ave.

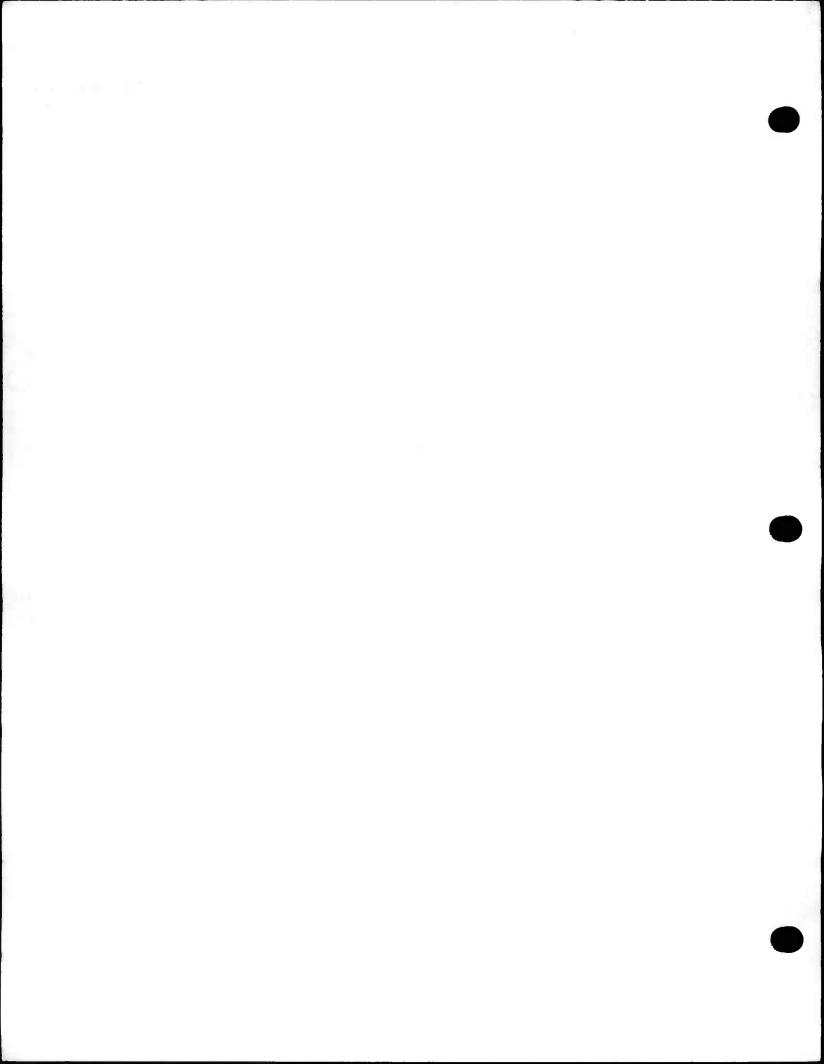


| DING PHYSICIAN: The law requires that the death certificate be executed within 2- rouns after death. Page 6 may be retained by the hospital or attending physician. | After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should heath with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | - |
|---|--|---|
| VG PHYSIC | to the FUNERAL DIRECTOR: After this certificate h | MPORTANT: If Item 28 is marked, or Item |

| | FOR 1 - STATE REGISTRAR | STATE OF MA | ARYLAND / | DEPART ERTIFIC | MENT OF H | EALTH AND I | | YGIENE EG. NO. | 90 | 34041 |
|---|--|--|---------------------------------|--|---|---|-------------------------------------|-----------------------------------|------------------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Beatr | زده ر | OWENS | S, BEAT | TRICE | 2. DATE OF MONTH 12- | DEATH DAY | YEAR | 8;10p M |
| | 4. SOCIAL SECURITY NUMBER 218-07-4919 | 5. SEX 1 M 2 F | 81 | t birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF II (Month, De 07-2 | | Country) | LACE (State or Foreign |
| TOR | 99. FACILITY NAME (If not institution, give st CHURCH HOSP: RESIDENCE OF DECEDENT | | RPØRAT: | - 1 | | R LOCATION OF DE | EATH | Sc. Ci | OUNTY OF DEA | ATH |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | | TY, TOWN OR LOCATION ALTIMORE | | | | 1 | IOd. INSIDE CITY X LIMITS? YES 2 \(\text{NO} \) NO |
| FUNERAL | 100. STREET AND NUMBER 209 S BETHI | EL STREE | T | | 10f | 21231 | Pel. | 10g. (| USA | |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 XWidowed 4 Divorced | 12. WAS OECEDENT FORCES? 1 [IF YES, GIVE WAR | YES 2 XN | MED IO | If yes, spi | ENDENT OF HISPAN icity Cuban, Mexice 2 NO Specify | n, Puerto Ricai | pecify Yea or No- n, etc.) | - 14. RACE - Black, Specify: | - American Indian, White, etc. |
| COMPLETED | 15. OECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12) 9 th Grade | CATION completed) College (1-4 or 5 +) | (Gi | CEDENT'S U ive kind of wo Do NOT use | SUAL OCCUPATION or done during mo retired.) | N all of working | 16b. KIN | ID OF BUSINESS/ | INDUSTRY | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | | le, Maiden Surname | , | hnson |
| BE | W LLLLAM 19a. INFORMANT'S NAME (Type/Print) | William Morton FORMANT'S NAME (Type/Print) 196. MAIL | | | | | iana Route Number, | City or Town, State, | | nnson |
| 입 | Brenda | Proctor | | | | hel St. | | | | |
| | 20a. METHOD OF DISPOSITION 10 Burlet 2 Cremetion 3 Remo 4 Donetion 5 Other (Specify) | oval from Stale | 20b. PLACE other pla Bal | of disposition) timo: | re Cem | etery | | Balti | - City or Tow More, | • |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | | | MARCH | | 1101 | E. NO | RTH AVE. |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Finei disease or condition resulting in death) | List only one cause | on each ilne | . • | | | h as cardiec | or respiratory | arrest, | Approximata Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, laading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | If sny, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| - | PART II. Other algnificent condition | s contributing to d | eath but not r | esulting in | the underlying | g cause given in | | PERFORMED? | - | WERE AUTOPSY FINDINGS WALLABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | | ACE OF DEATH (Ch | eck only one) | | | |
| IYSI | 1 TES 2 DNO | 1 Inpatient 2 🗆 I | | □ DOA | | e 5 🗆 Residence | | | | |
| ВУ РР | 1 Natural 5 Pending 2 Accident Investigation | | | 28b. TIME INJU | M 1 . | RK? /ES 2 NO | 26d. DESCRI | BE HOW INJURY | OCCURED | |
| | 3 Suicide 8 Could not be determined | 26a. PLACE OF building, at | INJURY — At ho ic. (Specify) | me, farm, at | reet, factory, offic | | 26f. LOCATIO | ON (Street end Nun own, State) | nber or Rural Ro | ute Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSI 2 MEDICAL EXAMINE | CIAN: To the best of m | | | | | | | | end menner ee stated. |
| B | 29b. SIGNATURE AND TITLE OF CERTIFIER | Martin | mo | | | 29c. LICENSE NUI | MBER 7330 | 29d. | | Month, Day, Year) 8/90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | |

*. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Year)
DEC 11 1990



BALTIMORE, MARYLAND 21203-3146

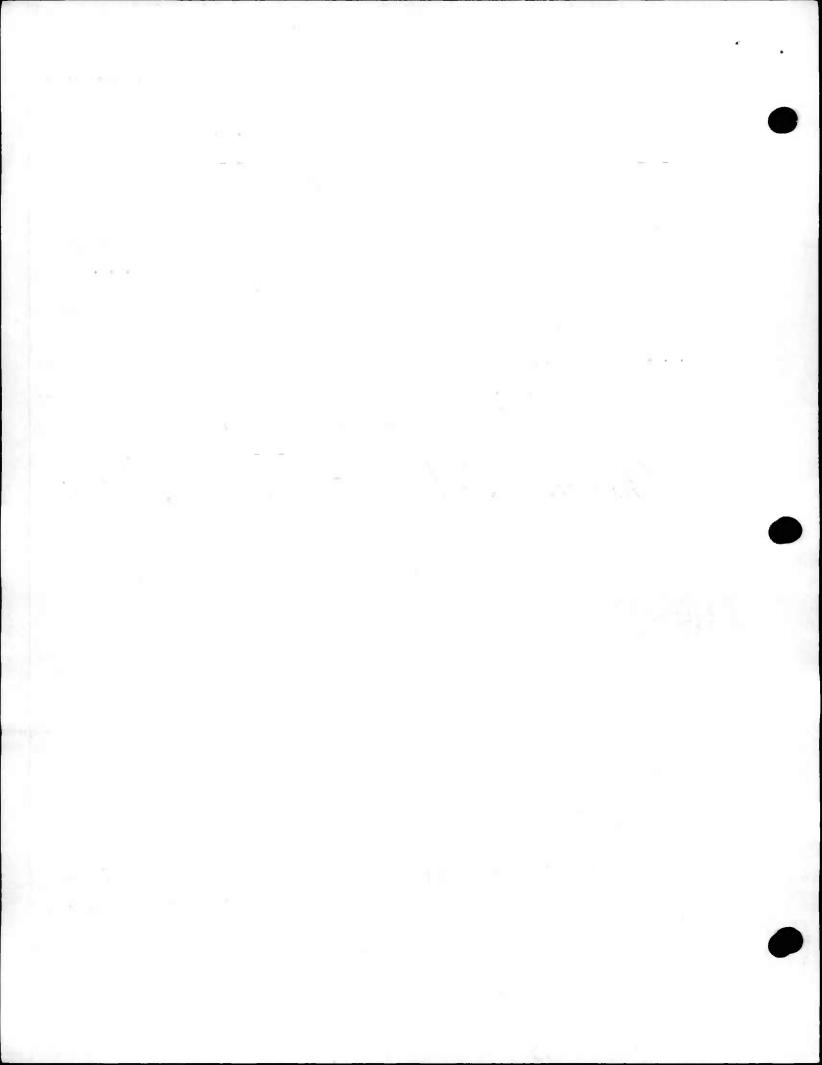
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| BALTIMORE, MARYLAND 21203-3146 | HYSICIAN: The law requires that the death certificate be executed within nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | , the medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the fu | be filed within 72 hours are deem with the state begin, or regard and mental hybring provide country, or convers. IMPORTANT: If I liem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

34045 90

| | FOR STATE REGISTRAR | STATE OF MARYLAND | / DEPAR | | | | | | YGIENE EG. NO. | 9 | 0 3 | 34045 |
|-----------------|---|--|---------------|---|-------------------------|--------------------------|-----------------|--|---|-------------------------------|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | JERRY HAROL | D PURC | ELL | | 7 % | | 2. DATE OF E | | 90 ' | 7EAR 3. 1 | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 213-40-2031 | 5. SEX 6. AGE (In yrs. 1)XX M 2 F 49 | 4 | IF UNDER | 1 YEAR DAYS | # UNDER | 24 HRS. MIN. | 7. DATE OF 8 (Month, Der 1-1 - 3 - | 7. DATE OF BIRTH (Month, Dey, Year) 11-3-1941 8. BIRTHPLACE (State or Foreign Country) TENNESSEE | | | |
| FOR | 90. FACILITY NAME (If not institution, give a 1306 THIRD ROAD RESIDENCE OF DECEDENT | street and number) | | 9b. CITY, | | | RIVEI | | | 9c. COUNTY OF DEATH BALTIMORE | | |
| DIRECTOR | 10a. STATE 10b. COUNT | | 10c. CIT | Y, TOWN O | | | | | | | 10d | I. INSIDE CITY LIMITS? |
| | MARYLAND E | | | | _ | DD LE | RIV | ER | | 10a. CITIZE | | YES 2 XIXIO |
| FUNERAL | 1306 THIRD ROAD | | | | | | 212 | 20 | | | u.s. | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried Merried 3 Divorced | 1 Never Merried 2 Merried FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES | | | 1 □ VES X X NO Specify: | | | | | | Black, Wi Specify: | American Indian, hite, etc. WHITE |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | e completed) | (Give kind of | ECEDENT'S USUAL OCCUPATION tive kind of work done during most of working Do NOT use retired.) 16b. KINO OF BUSINESS/INDUSTRY | | | | | | | | |
| COMPLETED | G.E.D. | College (1-4 or 5+) N/A | | IVER | | | | | Pu | ROLAT | OR SE | RVICES |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) HAROLD RALPH PURC | CELL, SR. | | | | | CHAR | NE (First, Middl LOTTE | BOWE | RS PU | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) JOHNETTA MARIE | - | 196. MAILING | | | | | oute Number, (IMORE. | | , State, Zip C YLAND | | 1220 |
| | 20a. METHOD OF DISPOSITION XX Burlel 2 Gremation 3 Gren | noval from State 20b. PLA | VCE OF DISPO | SITION (Na | me of cer | netery, cren | natory or | | 20c. LOC | ATION — CI | ty or Town, | State |
| | 4 Donation 5 Other (Specify) | | DOWRID | 22. | NAME A | ID ADDRE | SS OF FAC | HLITY | | | | IARYLAND |
| | · Charle | V. tish | / | | | | | EKAL H VUE D | | | | , INC. 21222 |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. | complications that caused the List only one cause on each | | not enter | the mo | de of dy | ing, such | aa cardiac | or reapin | atory arres | nt, | Approximate Interval Between |
| | disesse or condition resulting in death) a. Carper afor Pariser | | | | | | | | | Onset and Death | | |
| | | DUE TO (OR AS/A CON | A A A | WO. | DA | r. 00 | C04/ | cuon | D | H.P. | 4.00 | |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A COR | NSEOUENCE C | PF): | | une. | Cora | Myru | | ,,,,, | 7 | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events | IUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERI | resulting in death) LAST | d | | | | | | | | | | |
| CAL | PART II. Other algnificant condition | na contributing to death but n | ot resulting | In the un | nderlyln | g ceuse | given in i | | PERFOR | MED? | AM | ERE AUTOPSY FINDINGS AILABLE PRIOR TO EMPLETION OF CAUSE |
| MEDI | | | | | | ····· | | _ ' | YES 2 | □ NO | 1 | DEATH? |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL | | | | 2/I PI | ACE OF I | FATH (Che | ack only one) | | | | |
| SICI | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient | nt 3 🗆 DOA | OTHEI 4 Nur | R: | | | 6 Other (S | pecify) | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. Til | WE OF JURY M | W | IURY AT ORK? YES 2 | □ NO | 28d. OESCR | IBE HOW IN | JURY OCC | JREO | |
| 8 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — / building, etc. (Specify) | M home, farm, | street, fact | tory, offic | :e | | 28f. LOCATION OF T | ON (Street a fown, State) | nd Number o | or Rural Rout | e Number, |
| COMPLET | one) | SICIAN: To the best of my knowledg | | | | | | | | | | nd manner es stated. |
| B | 296. SIGNATURE AND TITLE OF CERTIFI | Rollon 11 | w | | | 29c. LIC | 79 | BER 30 | | 29d. DATE | SIGNEO (M | 7 - 90 |
| 5 | M. HAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DEATH | EL | On | MA | N, | MO | 3 | 015 | 34. 0 | 201 | Place |
| | DEC 1 1 1990 du | 32. REGISTRAR'S SIGNATU | RE | | | | | | | | | |
| | TUL 11111 700 | The state of the s | | | | | | | - | | | OHMH-16 Rev 1/89 |

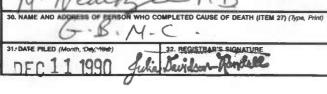


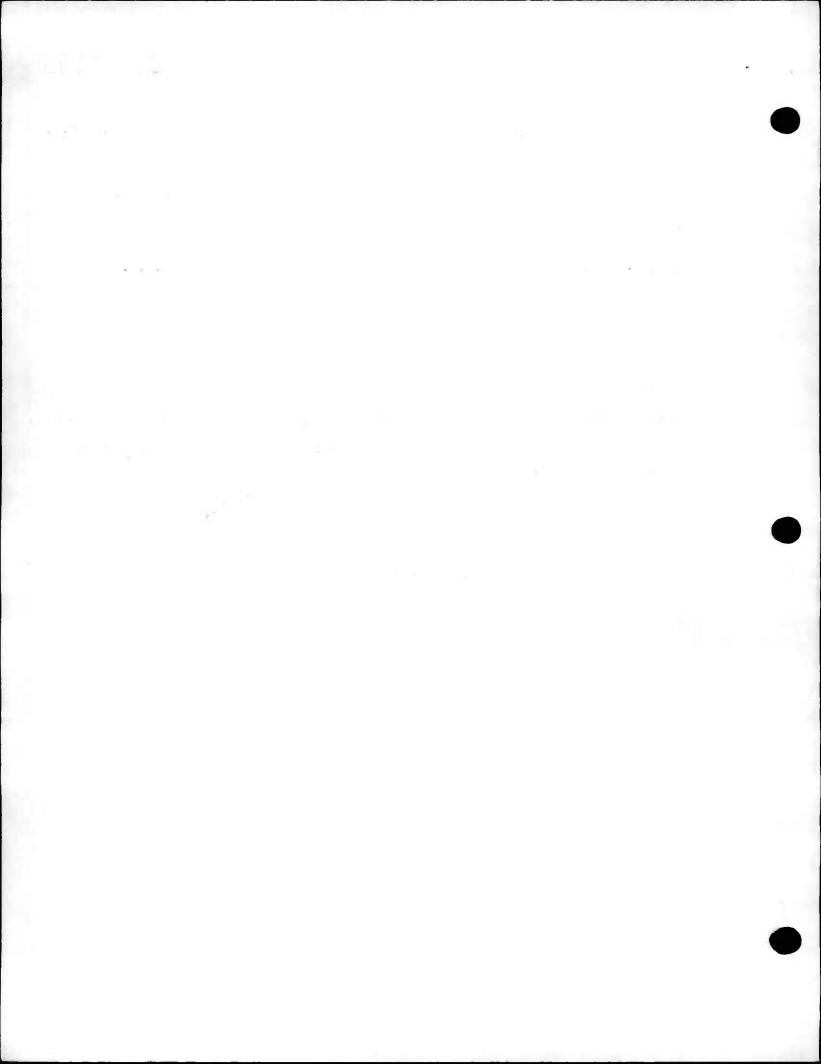


| 12146 | |
|----------|------|
| ROX X | |
| C | |
| SUBCULIA | |
| OF VITAI | 1011 |
| NOISIVIE | |

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Lx-, nours after death. Page b may be floating by the hospital or attending physician. To THE FUNERAL UNRECTOR: After this certificate has been signed by the attending physician and completing filled in the funeral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hyghere prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or Item 28 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|
| |

| | | | | | | | | | | | | 30 | 340 | 46 |
|------------------------|--|-------------------------------|--------------------------|------------------------|----------------|-------------|-------------------------------|----------------|---------------------|-----------------------------|-----------------|------------------|------------------------------------|-----------|
| | 1 - SIAIE | TATE OF MA | RYLAND / | DEPAR | TMENT | OF H | EALTH | AND N | | | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | CE | HIIF | ICATE | = OF | DEAT | Н | | REG. NO. | | | 3. TIME OF OE | 711 |
| | MONTH DAY YEAR | | | | | | | | | | 8:15 A | | | |
| | | SEX 6 | ASQUAL AGE (În yrs. last | hirthdau) | IF UNDER | 1 VEAD | IF UNDER | 24 MBC | 7. DATE OF | | 5, 19 | | IPLACE (State or | |
| | | □ M 2XXF | 90 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, E | 5/190 | _ | Counti | γ) | Orongii |
| | 9a. FACILITY NAME (If not institution, give street | | 90 | | Oh CITY | TOWN | R LOCATIO | N OF DE | | 0/ 190 | | | ryland_ | |
| œ | Greater Baltimore | - | | wsor | | M OF DE | oc. county of death Baltimore | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | Hedical | Center | | 10 | JWSUI | 1 | | | | Dar | CTIIIC | ore | |
| Ä | 10e. STATE 10b. COUNTY | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CIT | ΓY | | |
| | Maryland Balti | lmore Ci | ty | | Balt | imon | re | | | | | | 1 X YES 2 | NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 101. | ZIP CODE | | | | 10g. CITI | ZEN OF V | VHAT COUNTRY? | |
| 띨 | 1204 W. 41st Stree | et | | | | | 21 | 211 | | | U. | S.A. | | |
| 5 | | WAS DECEDENT E | EVER IN U.S. AR | MED | 13, | WAS DEC | ENDENT O | F HISPAN | NC ORIGIN? | Specify Yes | or No- | 14. RACI Blac | E — American Inc k. White, etc. | dien, |
| BY | 1 Never Merried 2 Merried 3 Widowed 4 Otvorced | IF YES, GIVE WAR | | | | 1 YES | 2XXN0 | Specify | n, Puerto Ric ⁄: | 21, 010., | | Spec | ily: | |
| | 15. DECEDENT'S EDUCATION | | | | | | | | | ND OF BUI | 11/500/11/5 | | nite | |
| = | (Specify only highest grade com | pleted) | (Gi | ve kind of Do NOT u | work done | during mo | st of workin | g | 160, K | IND OF BUS | INESS/INU | USTRY | | |
| 7 | Elementary/Secondery (0-12) Co | ollege (1-4 or 5+) | 1 | | naker | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | -0 | idite | | 18. MOTH | IER'S NAI | ME (First, Mic | dle, Maiden | Surneme) | | | |
| Ö | George Hare Clara | | | | | | | | | | | | | |
| 8 | 19e. INFORMANT'S NAME (Type/Print) | | 198 | . MAILING | ADDRES | S (Street e | | | Route Number | City or Tow | n, State, Zip | Code) | | |
| 임 | Kathryn Calderone | Kir | ngs F | Ridge | Roa | ad. Ba | ltimo | ore. | Mary | land 21 | 234 | | | |
| | 20e. METHOD OF DISPOSITION | | 20b. PLACE | OF DISPO | SITION (A) | ame of coo | neten cons | | , | | CATION - | _ | | |
| | 1X Burial 2 Cremation 3 Removal 4 Donation 6 Other (Specify) | 1rom State | Wo | odla | iwn C | Cemet | ery | | | Woo | dlaw | n, M | laryland | 1 |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | EE | ~// | | 22. | NAME AN | D ADDRES | S OF FA | Funer | o1 U | · · · · | | | |
| | humm 1 | SUNCION | Alex. | ns | 3 | 631 | F ₂ 11 | : 1155 e Ro | runer R | al no | ore | Mar | wland 3 | 1211 |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiac or respiratory errest, Approximate | | | | | | | | | | | | | |
| | ahock/ or heart fellure. List only one cause on each line. | | | | | | | | | | | | | |
| | disease or condition | | | | | | | | | | | | | |
| | resulting in death) • UC O O O O O O O O O O O O O O O O O O | | | | | | | | | | | | | |
| z | 1 sans | | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| 8 | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | | 1 | | |
| E | that initiated events | DUE TO (O | OR AS A CONSEC | DUENCE C | PF): | | | | | | | | | |
| EH | reaulting in death) LAST | | | | | | | | | | | | | |
| _ 1 | PART II. Other algnificant conditions co | ontributing to d | aath but not r | esulting | In the u | ndariyin | g cause (| given in | Part I. 2 | 4a. WAS AN | | 24 | . WERE AUTOPSY | |
| 2 | | | | | | | | | | PERFO | | | COMPLETION O | |
| 입 | | | | | 0.00 | | | | _ | [] 1E9 2 | | | OF DEATH? | 1 NO |
| ≥ | | | | | | | | | _ | | | | | , |
| Ž | 25. WAS CASE REFERRED TO MEDICAL | | - | | | 26. PI | ACE OF D | EATH (Ch | eck only one) | | | _ | | |
| PHYSICIAN: MEDICAL | | OSPITAL: ☐ Inpatient 2 ☐ I | ER/Outpatient 3 | □ DOA | OTHE 4 Nu | | ne 5 □ Re | sidence | 6 Other | Specify) | | . 4 | | |
| إ ₹ | 27. MANNER OF DEATH | 28a. DATE OF IN | | 28b. Til | ME OF | 28c. INJ | URY AT | | | RIBE HOW | NJURY OC | CURED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, | , rour) | " | JURY | 1 🗆 | YES 2 |] NO | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE OF building, et | INJURY - At ho | me, farm, | street, fac | tory, offic | • | | | ION (Street Town, State) | | r or Rural | Route Number, | |
| E | 4 Homicide determined | | 1-1 | | | | | | Jay or | , Jiero) | | | | |
| 1 5 | 29a. CERTIFIER 1 CERTIFYING PHYSICIAL | Y: To the best of m | ny knowledge, de | ath occur | red at the | time, date | and place | , end due | to the caus | e(e) end ma | nner as sta | ned. | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: C | on the basia of exa | mination and/or | investigat | ion, in my | opinion, c | leath occu | red at the | time, date e | nd place, e | nd due to t | he ceuse | (e) end manner e | a stated. |
| ŭ | 296. SCHATURE AND TITLE OF CERTIFIER | 1 | ^ | | | | 29c. LIC | ENSE NUI | MBER | | | | D (Month, Day, Yes | |
| 1 Newsyce MD 138784 ►/ | | | | | | | 12-10-90 | | | | | | | |

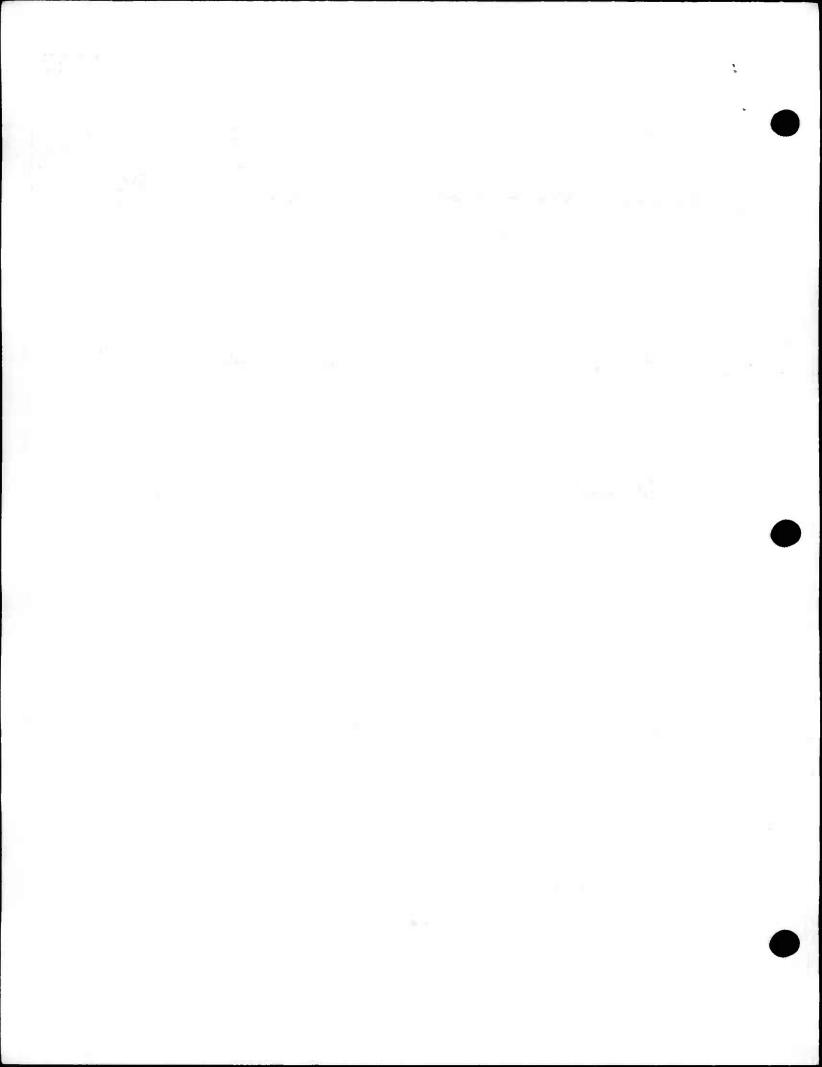




| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| RECOR | aw requires tha | s been signed spt. of Health a | 3 shows any |
| NTAL. | ICIAN: The | ertificate ha | or item 2 |
| ON OF | DING PHYS. | After this c | s marked, |
| NISI(| ATTEN! | MRECTOR: | em 28 i |
| ۵ | SPITAL D | JERAL DI | IT: H ite |
| | TO THE HOS | TO THE FUN be filed with | IMPORTAN |

| | FOR 1 - STATE REGISTRAR ELWOOD | | RYLAND / DEF | ARTMEN | T OF H | EALTH AND I | MENTAL HYG | | | |
|------------------|--|-------------------------------|----------------------------|------------------------------|---|----------------------|---|------------------|--------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | - CONTRACTOR | | | | | 2. DATE OF OEAT | Н | | 3. TIME OF DEATH |
| | Elwood - | T PRESSI | 2900 | | | | MONTH - | DAY | 1990 | 6:55 a m |
| | 4. SOCIAL SECURITY NUMBER | - | . AGE (In yrs. lest birtho | | R 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yes | | | IPLACE (State or Foreign |
| | 578-09-0843 | 1,XXM 2 □ F | 73 YR | S. MONTHS | DAYS | HOURS MIN. | Feb.4, | Ĩ917 | | ington,D.C. |
| | 9e. FACILITY NAME (If not institution, give | street and number) | 1 | 9b. CIT | Y, TOWN | R LOCATION OF DE | EATH | 9c. CO | UNTY OF D | EATH |
| DIRECTOR | Southern M | oruland | Hospital | | (| linton |) | | b) | G. |
| [គួ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | TY . | 10c. | CITY, TOWN | OR LOCAT | ION | | | | 10d. INSIDE CITY |
| E | Maryland Prince | Maryland Prince George's Temp | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | | | . ZIP CODE | | 10g. Cl | TIZEN OF N | WHAT COUNTRY? |
| FUNERAL | 2979-Brinkley Ro | ad, #101 | | | | 20748 | | Uni | ted S | States |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO | | | | | | NIC ORIGIN? (Specifion, Puerto Rican, etc | | 14. RACI | E — American Indian, k, White, etc. |
| BY F | 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES | | | | | ZYNO Specif | |) | Whit | |
| | 15. DECEDENT'S EDU | 1 ICATION | 100 DECEMBE | T'E LIEUAL A | DOC! IDAT! | N1 | Ter Kind O | E BURNIERS (IN | | _e |
| Ш | (Specify only highest grad | e completed) | (Give kind | of work done of use retired. | SUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY k done during most of working streed.) | | | | | |
| 7 | Elementery/Secondery (0-12) | College (1-4 or 5+) | Boile | r rep | airma | an | Potom | ac Ele | ctri | Power Co. |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (First, Middle, Mi | siden Surname) | | |
| BE C | Anthony Joseph | Pessagno | | | | Margar | et Rebe | cca T | homas | 5 |
| | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAI | LING ADDRES | SS (Street a | nd Number or Rural | Route Number, City of | r Town, State, 2 | (ip Code) | |
| 임 | Myrtle V.Pessagn | o (Wife) | 2979 | -Brin | kley | Road,#1 | 01,Templ | e Hill | s,MD | 20748 |
| | 20e. METHOD OF DISPOSITION 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ren | noval from State | 20b. PLACE OF DIS | SPOSITION (| lame of cer | netery, crematory or | | c. LOCATION - | | |
| | 4 🗋 Donetion 5 🗆 Other (Specify) | | Cedar H | | | | | uitlan | d, Mai | ryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE D'A | | J ²² | . Wil | D ADDRESS OF FA | 's Sons | Compan | y Fui | neral Home |
| | · Charles | r. Dela | nger | | | | | | | 0002-5816 |
| | 23. PART i. Enter the diseases, or | | | Do not enta | r the mo | de of dying, suc | ch ae cardlec or | respiretory s | rrest, | Approximsta interval Batween |
| | ehock, or heart failure. Liet only one ceuse on aech lina. IMMEDIATE CAUSE (Fins) | | | | | | | | | Oneat and Death |
| | disease or condition | | | | | | | | | 3 wtg |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | H11 4 |
| 8 | Sequentially list conditions, of 50 phased Stagmens all Carcinema DUE TO (OHAS A CONSEQUENCE OF): | | | | | | | | | |
| Ě | If sny, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| 윤 | CAUSE (Diseese or injury that initiated avents | DUE TO (C | R AS A CONSEQUENCE | E OF): | | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | |
| | PART II. Other significant conditio | ne contributing to d | aeth hut not result | ing in the s | an de dude | a anuan ahuan In | Book L San W | S AN AUTOPS | | . WERE AUTOPSY FINDINGS |
| SAL | A boesto en | | eeth but not result | ing in the c | maenym | g cause given in | PE | RFORMED? | 240 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | THE BUTCHEVERS | | | | | | 1 U Y | ES 2 XNO | | OF DEATH? |
| Σ | | | - | | | | — | | | 1 TES 2 NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | | 28 P | LACE OF DEATH (C) | neck anly one) | | | |
| Sign | EXAMINER? 1 YES 2 YOU | HOSPITAL: | ER/Outpatient 3 🗆 Do | OTHE | R: | | 8 Other (Specifi | 4) | | |
| ¥ | 27. MANNER OF DEATH | 28e. DATE OF IN | | TIME OF | 28c. fN. | JURY AT | 28d. DESCRIBE H | | CCURED | |
| <u>Б</u> | 1 Natural 5 Pending | (Month, Day, | (Year) | INJURY | | YES 2 NO | | | | |
| Э ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e, PLACE OF | INJURY — A1 home, fe | rm, street, fa | ctory, offic | • | 28f. LOCATION (S City or Town, | | oer or Rural | Route Number, |
| TED | 4 Homicide determined | - Conditing of | an (optionly) | | | | GRY OF TOWN, | 31010) | | |
| COMPLET | 290. CERTIFIER (Check only 1 CERTIFYING PHYS | SICIAN: To the best of m | y knowledge, death o | corred at the | time, date | and place, end du | e to the cause(e) en | d manner ee a | tated. | |
| No | onel | ER: On the basis of exe | minstion end/or invest | lgation, in my | opinion, | death occured at the | a time, data and pla | ca, end dua to | the cause(| e) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CENTURE | CR. | | | | 29c. LICENSE NU | MBER | 29d. D | | D (Month, Day, Year) |
|) BE | (a) - i Been | à | | | | D147: | 0 | > | 12- | 2-90 |
| 유 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE | OF DEATH (ITEM 27) | (Type, Print) | | | | | | |
| | Cal-lin Young, he | 1, 8156 C | lordyard R | d #1 | 01 | Chuton, 1 | 45 2013 | 1 | | |
| | 31. DATE Ell ED (Month Day Year) | THE REGISTRAD | Sight Markon | No | , | | | | | |
| | DEC 1 1 1990 | 1 | 35(25) | | | | | | | |





permit. Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or Item 23 shows eny Injury, or other traumatic event, the medical examiner must be notified at once.

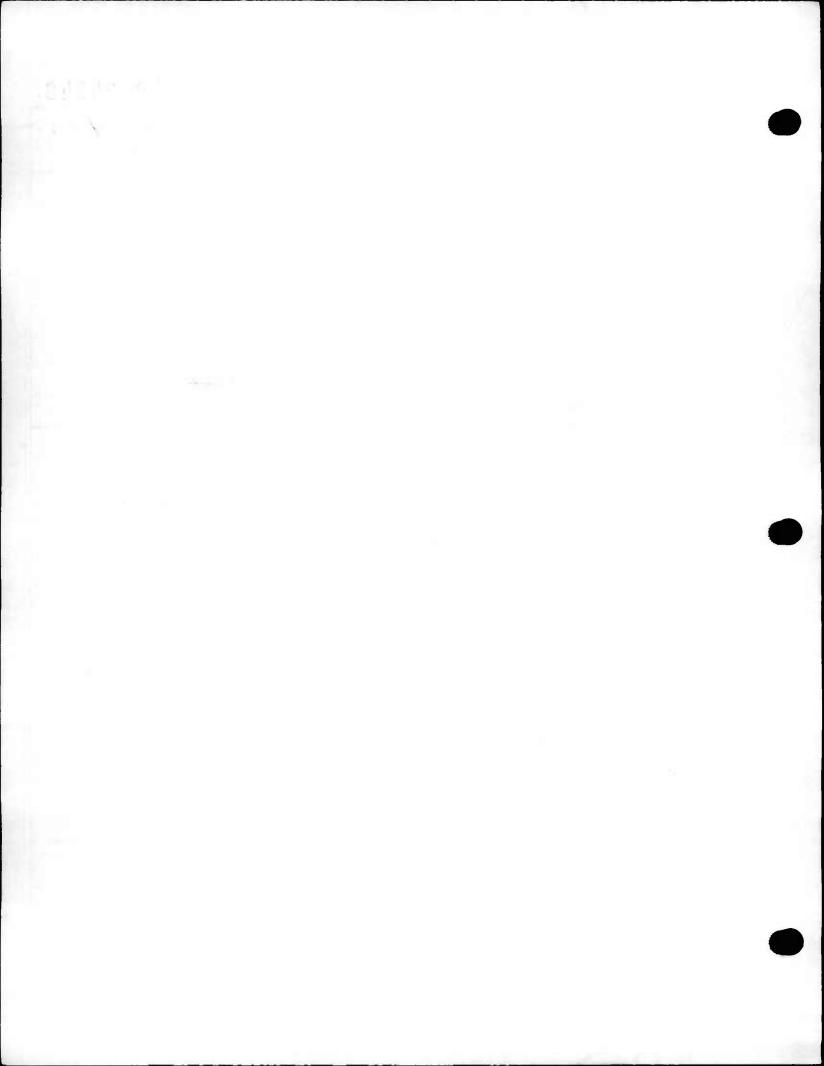
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR

CERTIFICATE OF DEATH OF REG. NO.

| | | | | | | 7 |
|-----|------|-----|-------|-----------|--------|---|
| 5 | So | A | 053 | KI SIM | B 1 5/ | 0 |
| 196 | W. | 00 | 2.2.5 | 4.91 | 1 15 | è |
| | and. | w | 1.00 | Property. | Took (| |
| | 1000 | 700 | 100 | 100 | | * |

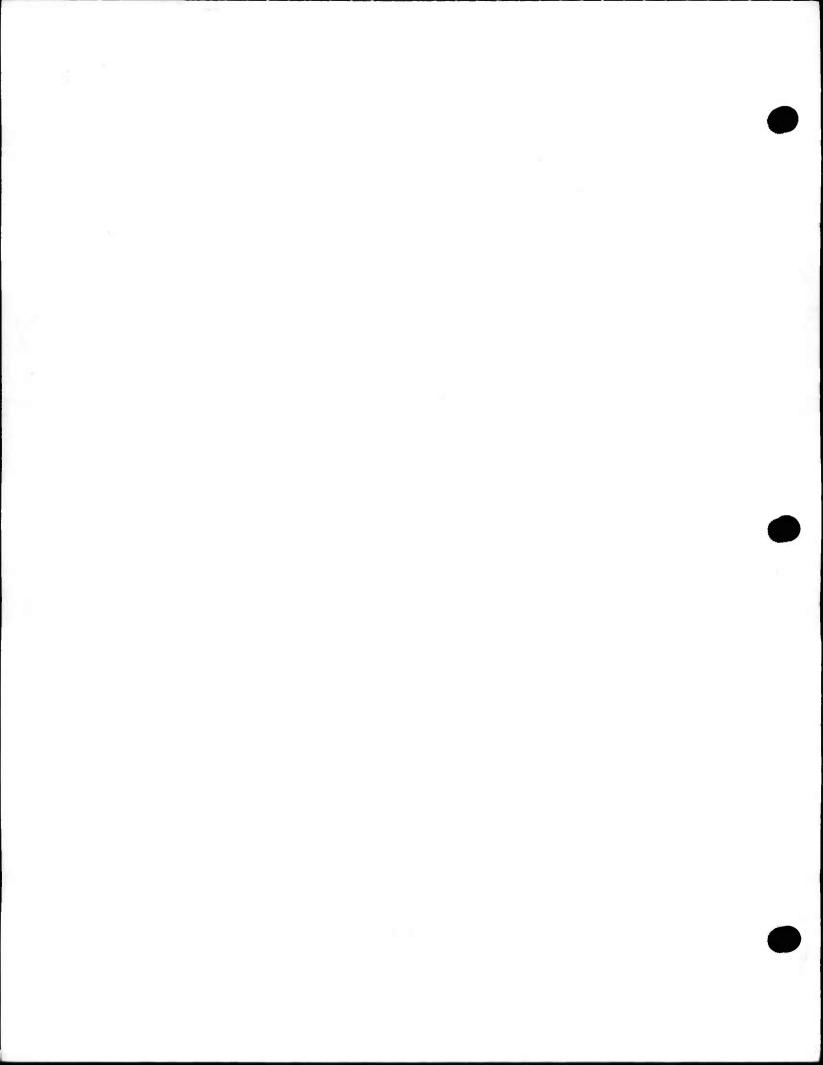
| REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG | 10. | 图 非营养 | 1040 |
|--|--|---|-------------------------------------|-----------------------------|---|-----------------------|------------------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | +NNA | | PRIC | E 200 | 2. BATE OF OBATH | DAY 4 9 | 3. TIME | F ZOA M |
| 4. SOCIAL SECURITY NUMBER 218-52-3651 | 5. SEX 6. AGE (| 85 YRS. MO | UNDER 1 YEAR INTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 05 8 | BIRTHPLACE (S Country) MARYL | |
| SINAL HOSP, RESIDENCE OF DECEDENT | eet and number) | 90 | BA | CTIM | ORE | 9c. COUNTY | OF DEATH | |
| 10a. STATE 10b. COUNTY | | 10c, CITY, T | OWN OR LOCAT | ION | | | 10d. IN | SIDE CITY |
| MARYLAND 10s. STREET AND NUMBER | | | BALTI | MORE ZIP CODE | | T | 1 🗓 1 | AITS? ES 2 NO |
| 6210 PARK HEIGHTS | | | 101 | 2121 | .5 | USA | N OF WHAT CO | UNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | | NIC ORIGIN? (Specify nn, Puerto Rican, etc.) y: | Yes or No- 14 | Black, White, Specify: WH | etc. |
| 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 18a. DECEDENT'S US (Give kind of work life. Do NOT use in | UAL OCCUPATION done during months.) | ON at of working | 16b. KINO OF | BUSINESS/INDUS | ТЯ | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | HOUSE | WIFE | | | HOME | | |
| 17. FATHER'S NAME (First, Middle, Last) JOSEPH KATZEN | | | | 16. MOTHER'S NA RACHA | ME (First, Middle, Maid EL | | REENBER | RG |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or | | | |
| MRS. LOIS SCHAPTE 20e. METHOD OF DISPOSITION 1 57 Burlal 2 Cremation 3 - Rame | 200 | . PLACE OF DISPOSITI | ON (Name of cer | | | LOCATION Ch | y or Town, State | |
| 4 Donation 5 Other (Specify) | | BETH' JACK | | ID ADDRESS OF FA | | FINKSBUF | RG,MD | |
| Ayoliney & St | tillucen | | SOL | LEVINSC | N & BROS. | | OPF.MD | 21215 |
| #3. PART I. Enter the diseases, or cannot be seen a super fine disease or condition resulting in death) | List only one cause on e. $ASPIR$ | d the death. Do not sech line. A TID N A CONSEQUENCE OF: | 01 | | | epiratory erres | in | pproximate iterval Between neet and Deeth |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C | A CONSEQUENCE OF): | | | | | | |
| PART II. Other significant condition | a contributing to death b | out not resulting in | the underlyin | g cause given in | PER | AN AUTOPSY FORMED? | AMAILAB | UTOPSY FINDINGS BLE PRIOR TO ETION OF CAUSE TH? |
| | | | | | | | 1 🗆 YI | ES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | ACE OF OEATH (C | | | | |
| 27. MANNER OF DEATH 1 | 128 Inpatient 2 ER/Out | 26b. TIME C | OF 28c. IN. | IURY AT HRK? YES 2 NO | 6 ☐ Other (Specify) 28d. DE\$CRIBE HO | W INJURY OCCU | RED | |
| 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, stre | et, factory, offic | • | 261. LOCATION (Str. City or Town, St | | Rural Route Nur | mber, |
| one) | CIAN: To the best of my know | | | | | | | nner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIES | 2. NAHUR | 1 , M. 8 | 7_ | 29c. LICENSE NU | MBER | 29d. DATE S | SIGNED (Month, | gay, Your) |
| 30. NAME AND ADDRESS OF PERSON WH E. NAHUM SINA | COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, PI | | ENSPRIN | KAVE. | B14. | NO 2 | 1215 |
| DEC 11 1990 | 52 HEGISTRAR'S BIG | Mintelland | | | | | | |



| ital of account projection. | for use as the burial-transit permit. Pages 1, 2, 3 should | | |
|---|--|---|---|
| TOICING THE INF EQUITED HIS USE USE LEGITICALE OF EXECUTED WITHIN \$4 HOURS BIND DESCRIPTION OF PORTION OF THE HOURS OF THE PROPERTY OF THE PRO | er this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | or to burial, cremation, or removal. | numatic event, the medical examiner must be notified at once. |
| J IME HUSPITAL OR ALLENDING PRINCIPAL. THE JAW TEQUIES WAS USE USED TO WHITE DESCRIPTIONS OF | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physicial | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or ren | MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notifiled at once |
| Ë ⊇ | D THE | be filed | MPO |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | | HYGIENE REG. NO. | 20 | 04015 |
|------------------|---|--|--|--------------------|-----------------------|-----------------------|---------------------------------|-------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Reinte, sr | | | | 2. DATE OF MONTH | | YEA | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In | yrs. last birthday) IF | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | | RTHPLACE (State or Foreign |
| | 212-12-4581 | 1 📈 M 2 🗆 F | 96 YRS. MO | THS DAYS | HOURS MIN. | | 5-189 | 3 | Chicago |
| OR | St. Agnes Hosp | Tal | 96 | 0 11 | R LOCATION OF DE | ATH | 1000 | COUNTY O | of Death |
| Б | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | Y | 10c, CITY, TO | OWN OR LOCAT | ION | | | | 10d, INSIDE CITY |
| FUNERAL DIRECTOR | | timore. | | timore | | | | | LIMITS? |
| BAL | 3330 Wilkens | Ave. | | | ZIP CODE 2/229 | | | | OF WHAT COUNTRY? |
| NO. | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U | J.S. ARMED | 13. WAS DEC | ENDENT OF HISPAN | | Specify Yee or No | S.A. | RACE — American Indian, Black, White, atc. |
| ВУ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATE | | | 2 □XNO Specify | | , | s | Specify: Thite |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during mo- | | 16b. K | IND OF BUSINES | S/INDUSTR | 77 |
| PLE | Elamentary/Secondery (0-12) | College (1-4 or 5+) | grocer | ureu.) | | foo | \sim | | |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | | 410001 | | 16. MOTHER'S NAI | | | me) | |
| BE | Fred Reinke | е | | | Marie W | itt | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural F | | | | |
| | Paul R. Reinke, J. 200. METHOD OF DISPOSITION | 20h 5 | 12811 Ha | | Ferry Re | d. Lar | | | 21227 or Town, Stata |
| 0 | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ram 4 ☐ Donation 5 ☐ Other (Specify) | oval from Stata | other place) keview Me | | iotory, ordinatory or | | | | e. Marvland |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | N.VIE.W MI | 22. NAME AN | D ADDRESS OF FA | | | | 21 - Dat y rank |
| | Joseph J | subru > | ,) | | se Funer Sulphur | | | | ıs. MD 21227 |
| | | complications that saused List only one cause on sac | the desth. Do not ch line. | | | | | | Approximate interval Batween Onset and Death |
| | iMMEDIATE CAUSE (Final disease or condition resulting in desth) | · Breum | my g | | | | | | Onset site beating |
| | | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | | | |
| CERTIFICATION | Sequentially list conditione, if eny, leading to immediate | | | | | | | | |
| FICA | cause. Enter UNDERLYING CAUSE (Disesse or injury that initiated events | C. DUE TO (OR AS A (| CONSEQUENCE OF): | | | | | | |
| E | resulting in death) LAST | d | | | | | | | |
| | PART II. Other aignificant condition | ns contributing to death bu | t not resulting in t | he underlyin | ceuse given in | Part i. 2 | 4a. WAS AN AUTO | PSY | 24b. WERE AUTOPSY FINDINGS |
| CAL | | | | | | | PERFORMED | ? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| PHYSICIAN: MED | | | | | | ' | | . | OF DEATH? 1 YES 2 NO |
| ä | | | | | | | | | |
| CA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 0 | 26. PI | ACE OF DEATH (Ch | eck only one) | | | |
| 14S | 1 ☐ YES 2 ☑ NO 27. MANNER OF DEATH | 125 Inpatient 2 ☐ ER/Output 26a, DATE OF INJURY | tlant 3 DOA 4 | | e 5 🗆 Raaldenca | | Specify) RIBE HOW INJUR | Y OCCUBE | in . |
| ВУ Р | Natural 5 Pending | (Month, Day, Year) | INJUR | Y WC | RK? | 204. 5240 | ALDE HOW INCOM | T OOCONE | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide detarmined | 26a. PLACE OF INJURY - building, etc. (Specif | — At home, farm, stre | et, factory, offic | | 281. LOCAT City or | TON (Street and N. Town, State) | umber or Ri | ural Route Number, |
| LET | 29a. CERTIFIER CONTENING PHYS | SICIAN: To the best of my knowle | ulas deith seemed | t the time date | and alone and dur | 40.45 | -(-) and | | |
| COMPLETED | | En: On the beals of examination | | | | | | | use(a) and manner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | | 1 - 1 | | 29c. LICENSE NUI | MBER | 290 | I. DATE SIG | ONED (Month, Day, Year) |
| TO B | for RU | | tusky | | 10240 | 5)- | • | 12 | 110/ |
| | 30. NAME AND ADDRESS OF PERSON WI | SMAN MY | | | mman | As . | Eny. | Pol | 2/21 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TURE | | 1000 | | | | |





Pages 1, 2, 3 should

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medical examiner

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HOSPITAL (FUNERAL C within 72 h To the hospita
To the funeral
Be filed within 72
IMPORTANT: II

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marked, with with

> 28 Hem

> > MARIO F. GOLLE, JR., MD

31. DE ELE (MT 11. P. 1990

32. REGISTRAR'S SIGNATURE

hospital or attending physician.

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| ó | with | ng physician and completely filled in giene prior to burlal, cremation, or r | |
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| L. | Sic | - to | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mount | L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or r | |
| S | TEN | TOR: | |
| ≥ | R AT | IREC NUTS | |
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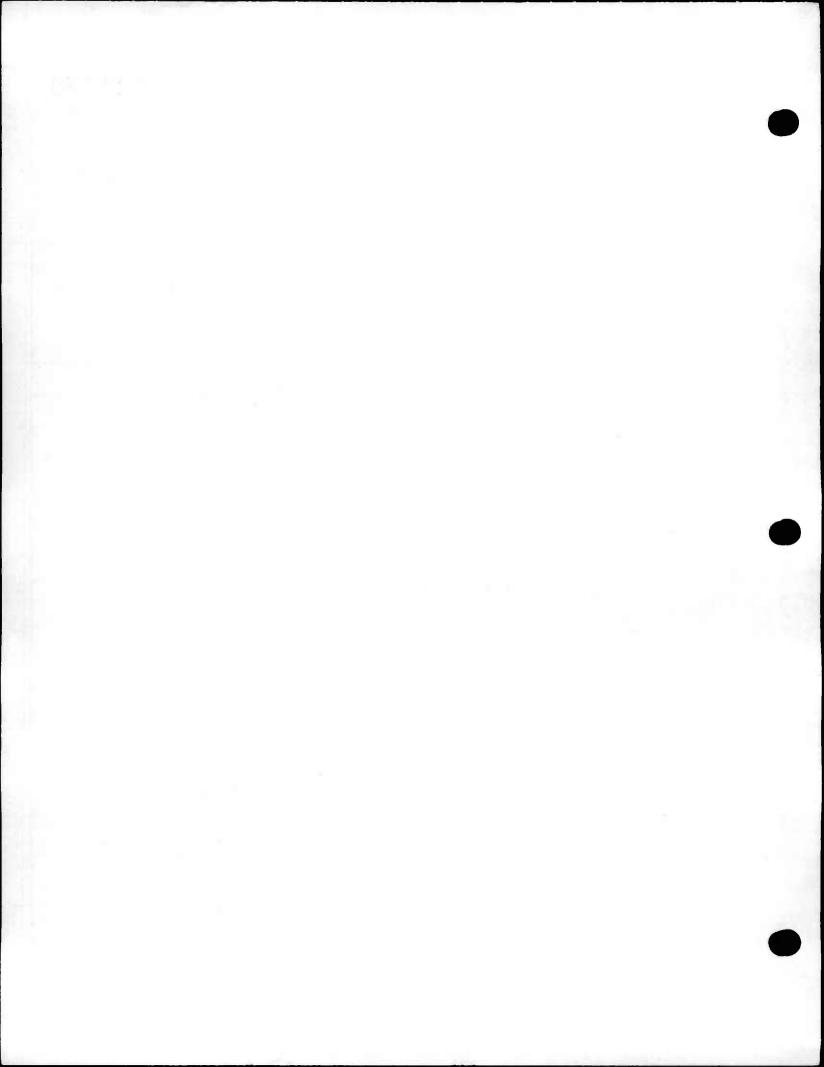
FOR STATE REGISTRAR 90 34050 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF OEATH YEAR Cletus G. Reinsel 12-4-90 5:40PM IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. 4. SOCIAL SECURITY NUMBER 7. DATE OF BIRTH 6-10-1937 5. SEY 6. AGE (In yrs. lest birthday) 6. BIRTHPLACE (State or Foreign 190-28-3891 53 Penn. 1 X M 2 | F VRS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OFATH St. Agnes Hospital Baltimore City DIRECTOR RESIDENCE OF DECEDENT 106. COUNTY Venango County Sugar Creek Borough 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Penn. Oil City 1 X YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE Rd 1 Shaffer Run Rd. U.S.A. 16301 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 X NO 14. RACE — American Indian, Black. White, etc. 1 Never Married 2 Married IF YES. GIVE WAR OR DATES Specify: White BY 3 Widowed 4 Divorced G 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16e, DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET nentary/Secondary (0-12) College (1-4 or 5+) 12 yr's Communication Specalist Motorola 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Norbert Reinsel Josephine Cyphert BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Antoinette Reinsel Same as #10 20s. METHOD OF DISPOSITION
1 ☑ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20c. LOCATION — City or Town, State Clarion Cemetery 12/8/90 Clarion, Penn. 4 Donation 8 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Baltimore, Md. 21214 Paul L. Hartsock, Jr. Haul Hautory Leonard J. Ruck, Inc 5305 HArford Rd., 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardisc or respiratory arrest, abock, or heart failure. List only one cause on each line. Approximate interval Betw IMMEDIATE CAUSE (Final Onset and Dasth disease or condition . Hypertensive arteriosclerotic cardiovascular disease resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated event reaulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MIAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 TES X NO DF DEATH? 1 TYES XX NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Outpatient 3 | DOA EXAMINER? OTHER: ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED XX Natural 5 Pending м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 4 🗌 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. XX MEDICAL EXAMINER: On the basis of at and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(a) and manner as stated. 264 SIGNATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12-5-90 **OCME** 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

VC

111 Penn Street, Baltimore, MD 21201

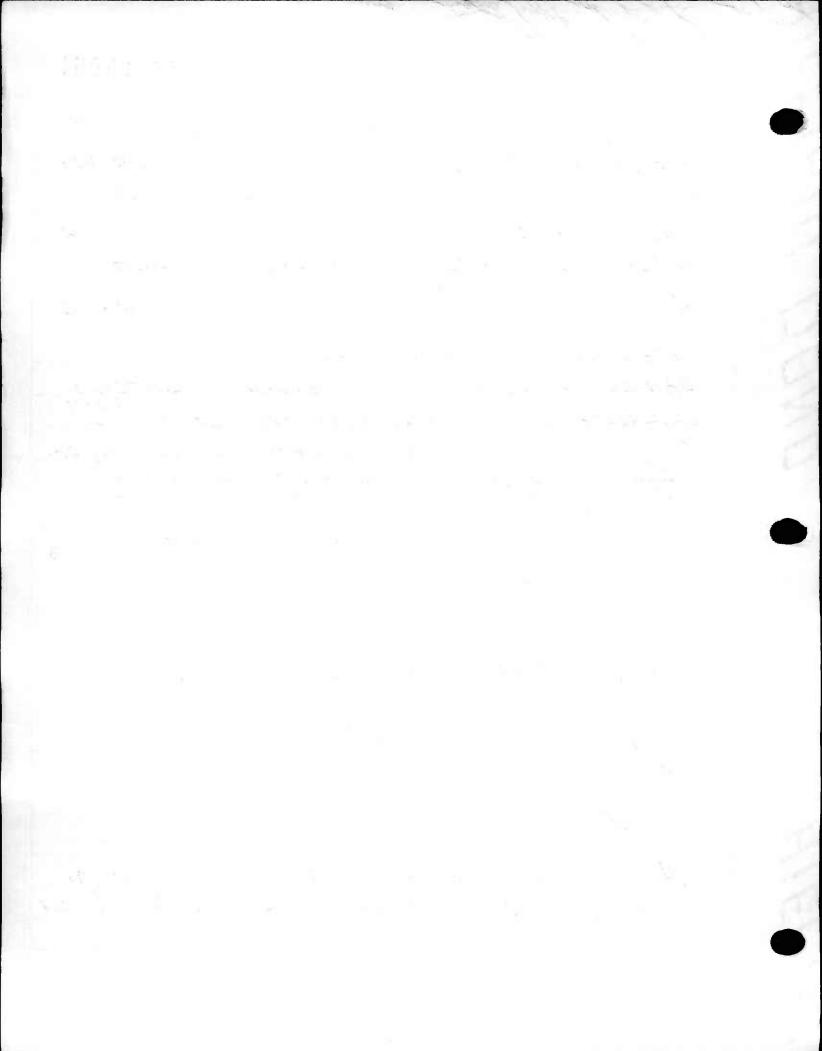


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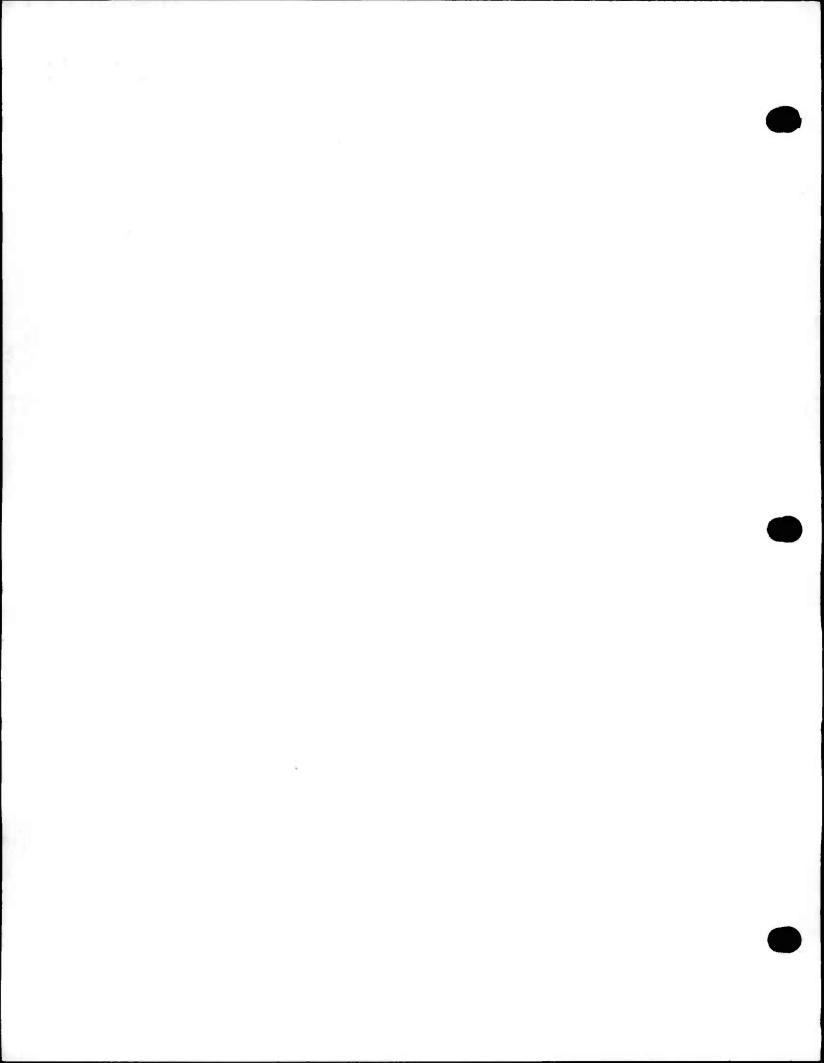
| L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attending physician. | 1. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, 3 should be not after health and Mental Hydiene prior to burlal, cremation, or removal. | filem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|
| TO THE HOSPITAL OR ATTENDING PHY | TO THE FUNERAL DIRECTOR: After this the filed within 72 hours after death with | MPORTANT: If Item 28 Is marke |

| | FOR STATE REGISTRAR | STATE OF MARYLAN | | NENT OF HEA | | NTAL HYGIEN | E | 0400. |
|------------------|--|---|--|--------------------------------|--|--|-------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | m | | Riege | C 2. | DATE OF DEATH | Y GE | 3. TIME OF DEATH |
| OR | 4. SOCIAL SECURITY NUMBER 276-62-7445 9a. FACILITY NAME (If not institution, give s | 10 M 2 OKF 96 | YRS. MO | | DOCATION OF DEATH | | 0 | |
| DIRECTOR | MD, BA | LTO. | 10c. CITY, TO | OWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 4709 RUL | | | 101. ZIF | 1227 | | U | OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES | 25NO | If yee, specify | ENT OF HISPANIC C Cuban, Mexican, Pr NO Specify: | ORIGIN? (Specify Yea uerto Rican, etc.) | | RACE — American Indian, Black, Whita, etc. Specify: Wiff TE |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elamentary/Secondary (0-12) | completed) Cotlege (1-4 or 5+) | a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during most of tired.) | | 16b, KIND OF BUS | SINESS/INDUST | RY |
| ŏ O | 17. FATHER'S NAME (First, Middle, Last) | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | First, Middle, Malden | Surname) | |
| | DANIEL O | CONNELL | | | FLLE | N | Cos | TELLO |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street and It | lumber or Rural Route | Number, City or Tow | n, State, Zip Cod | 0 21727 |
| ٩ | EL1ZABETH | WISSMAN | 4709 | RUBS | AVE | | LTO. | MD. |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | 20b. PL | ACE OF DISPOSITION PROPERTY OF THE PROPERTY OF | 843 | crematory or | 20c. LO 57, | CATION City | or Town, Stata |
| | 21, SIGNATURE OF FUNERAL SERVICE LI | : Weber | | EDWA 5311 | | WEBE | RF | , |
| | 23. PART I. Enter the diseases, or ahock, or heart feilure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. DUE TO (OR AS A CO | iline. | enter the mode | of dying, such as | s cardiac or reapl | ratory arreat, | Approximata Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE TO (OR AS A CO | | | | | | |
| Ŋ. | PART II. Other significant condition | / / | not resulting in t | | use given in Par | t I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PLACI | OF DEATH (Check | only one) | | |
| | 1 YES 2 NO 27. MANNER OF DEATH 1 Mittural 5 Pending | 1 □ Inpatiant 2 □ ER/Outpatie 26s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | Y WORK | | Other (Specify) | NJURY OCCUR | ED |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datermined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, stre | | | of. LOCATION (Street City or Town, State) | and Number or F | tural Route Number, |
| COMPLETED | combon dray | ICIAN: To the best of my knowledg | | | | | | use(s) and manner as stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | Kone h | 15 | | D /3 / | 7 O | 29d. DATE SH | SNED (Month, Day, Year) |
| | 30' NAME AND ADDRESS OF PERSON WITH THE PROPERTY OF THE PROPERTY OF THE PROPERTY OF THE PERSON WITH THE PERSON | 10 COMPLETED CAUSE OF DEATH | met 1 | Vins | ing He | nie k | Balto | . ml. 21228 |
| - 1 | DELLE MAIL GO | Ka Laundren hande | | | | | | |





| 1 | FOR STATE REGISTRAR | TATE OF MARYLA | | | HEALTH AND I F DEATH | MENTAL HYGIEN REG. NO. | E | |
|------------------------------------|--|--|--|---|--|---|--|--|
| | 1. DECEDENT'S, NAME (First, Middle, Last) | | REE | > | | 2. DATE OF DEATH | - 9EA | 3. TIME OF DEATH |
| | 2 - 7/11 | 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 MONTHS DAYS HOURS | | | | 7. OATE OF BIRTH (Month, Day, Year) | 300 S. BI | erthplace (State or Foreign untor) Virginia |
| e B | 99. FACILITY NAME (If not institution, give street at | HUSPICA | | BALLI | MORE, | | 9c. COUNTY O | |
| DIRECTOR | 100. STATE Md. 10b. COUNTY Ba | | | TOWN OR LO | CATION Le River | | 10d. INSIDE CITY LIMITS? | |
| AL D | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | 10g. CITIZEN C | 1 ☐ YES 2 🙀 NO F WHAT COUNTRY? |
| FUNERAL | 10 Forest Roa | | | | 212 | 20 | | USA |
| à | 1 News Married 2 Married | Was decedent ever in Forces? 1 _ Yes If Yes, give war or da | 2 NO | If yes, | ECENDENT OF HISPAN apacify Cuben, Mexica ES 2 NO Specify | | S | ACE — American Indian, lack, White, atc. pecify: White |
| PLETED | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp. Elementary/Secondary (0-12) Col. | | | JSUAL OCCUPA ork done during retired.) | most of working | 18b. KIND OF BUS | SINESS/INDUSTR | Y |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | nou | SEWIL | T | ME (First, Middle, Maiden | Surname) | |
| BEC | Paris Reed | | | | Dru | zillia 1 | Reed | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Yow | | |
| - | Herbert Reed 20s. METHOD OF DISPOSITION | 20b. | PLACE OF DISPOSE | | t Road | Baltimore 20c.LO | CATION — City o | |
| | 1 Donation 5 Other (Specify) | rom State | Gardei | ns of | Faith C | emetery | Ross | ville Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSE | uneral | Home | | and address of fa nellyFun | | 300MAc | eAve.21221 |
| _ | | | 1 1/1/ 1 | mark . | | | | |
| 7 | 23. PART I. Enter the diseases or comp ahock, or heart faltere. List of | lications that caused only one ceuse on as | the death. Do no | ot enter the | mode of dyling, euc | h se cerdiec or respi | ratory arrest, | Approximate Interval Between |
| İ | 23. PART I. Enter the diseases or companock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) | SEPS | ch line. | | | | ratory arreat, | |
| NO | ahock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) | SEPS BOUE TO (OR AS A | ch line. CONSEQUENCE OF | · Pi | NEUM | | ratory arreat, | Interval Between |
| CATION | shock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | SEPS BOUE TO (OR AS A | ch line. | · Pi | | | A | Interval Between |
| ERTIFICATION | shock, or heart fallure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | BOUE TO (OR AS A | ch line. CONSEQUENCE OF |): Pr | | | A | Interval Between |
| | shock, or heart falture. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | consequence of consequence of consequence of |):): tha underly | VEUM | DN A | A A A A A A A A A A A A A A A A A A A | Interval Between Onset and Death Pour 12 HRS |
| DICAL CERTIFICATION | shock, or heart fallure. List of the control of the | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | consequence of consequence of consequence of |):): tha underly | VEUM | DN A | AUTOPSY INEED? | Interval Between Onset and Death Bour 12 HRS |
| ZAL ZAL | shock, or heart fallure. List of the control of the | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | consequence of consequence of consequence of |):): tha underly | VEUM | Part I. 24e. WAS AN PERFOR | AUTOPSY INEED? | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AMAIL ABLE PRIOR TO COMPLETION OF CAUSE |
| ZAL ZAL | shock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant conditions condi | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | consequence of consequence of consequence of | the underly | VEUM | Part I. 24e. WAS AN PERFOR | AUTOPSY INEED? | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AMAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| ZAL CAL | shock, or heart fallure. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other aignificant conditions co | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF CONSEQUENCE OF | tha underly 28 | VEUM | Part I. 24e. WAS AN PERFOR 1 U YES 2 | AUTOPSY INEED? | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AMAIL ABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | ahock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART, II. Other aignificant conditions cond | DUE TO (OR AS A | CONSEQUENCE OF CONSEQUENCE OF | other: Other 28c. URY 28c. | FLACE OF DEATH (CA | Part I. 24e. WAS AN PERFOR 1 U YES 2 | AUTOPSY INCEP? | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | ahock, or heart fallare. List of IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART, II. Other aignificant conditions cond | DUE TO (OR AS A OR AS A DUE TO (OR AS A DUE TO (OR AS A) | CONSEQUENCE OF CONSEQUENCE OF CONSEQUENCE OF It not resulting in White the consequence of | or tha underly the underly 28 OTHER: 4 Nursing E OF URY M 1 | PLACE OF DEATH (Cr. INJURY AT WORK? YES 2 NO | Part I. 24e. WAS AN PERFOR 1 VES 2 | AUTOPSY INED? AND NJURY OCCURE AND AND AND AND AND AND AND AN | Interval Between Onset and Death POUT 12 HRS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | ahock, or heart fallare. List of the control of the | DUE TO (OR AS A DUE TO | consequence of Conseq | OTHER: A Nursing Local Parent, factory, of dat the time, of | PLACE OF DEATH (Chiome 5 Residence Injury AT WORK? YES 2 NO | Part I. 24e. WAS AN PERFOR 1 VES 2 Deck only one) 8 Other (Specify) 28d. DESCRIBE HOW IN The City or Town, State) a to the cause(s) and main | AUTOPSY INEED? INJURY OCCURE and Number or Ru | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | ahock, or heart fallare. List of the control of the | DUE TO (OR AS A DUE TO | consequence of Conseq | OTHER: A Nursing Local Parent, factory, of dat the time, of | PLACE OF DEATH (Chiome 5 Residence Injury AT WORK? YES 2 NO | Part I. 24e. WAS AN PERFOR 1 YES 2 Book only one) 8 Other (Specify) 28d. DESCRIBE HOW IN City or Town, State) a to the cause(a) and main time, date and place, er | AUTOPSY NED? NO NJURY OCCURE and Number or Re and Number or Re and due to the cau | Interval Between Onset and Death Pour 12 HRS 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | ahock, or heart fallure. List of the control of the | DUE TO (OR AS A DUE TO | consequence of Conseq | tha underly 28 OTHER: 4 Nursing H E OF 28c. URY M 1 [treet, factory, of the time, of the | PLACE OF DEATH (Critical Street of Death (Cr | Part I. 24e. WAS AN PERFOR 1 YES 2 **Deck only one) 8 Other (Specify) 28d. DESCRIBE HOW IN A City or Town, State) 1 time, date and place, er | AUTOPSY NED? NO NJURY OCCURE and Number or Re and Number or Re and due to the cau | Interval Between Onset and Death Onset O |



| BALTIMORE, MARYLAND 21203-3146 | h. Page 6 may be retained by the hospital or attending phys | eral director, page 5 should be detached for use as the buni |
|--|---|--|
| BAL | - Just after deal | illed in by the fun |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | . OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 actions after death. Page 6 may be retained by the hospital or attending physic | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunia |

the hospital or attending physici

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

31. DATE FILED (Month, Day, Year)

1990

2. OATE OF DEATH MONTH RICHARDSON YEAR 90 GOLDIE 17 12 8. AGE (In yrs. 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Country) A SOCIAL SECURITY NUMBER 5. SEX lest birthday) IF UNDER 1 YEAR MARYLAND MONTHS DAYS HOURS MIH. 9 19-30-9418 1 M 2 W 10 1 9e. FACILITY NAME (If not institution, 9b. CITY. TOWN OR LOCATION OF GEATH 9c. COUNTY OF OEATH ST. JOSEPH HOSPITAL Towsa INPERINGE DIRECTOR 10a. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY Bal MD TON TIMOTE Monk YES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 101, ZIP CODE BIG FA16 211 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Bleck, White, etc. If yee, specify Cuban, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: Never Married 2 Merried IF YES, GIVE WAR OR DATES Black BY the t 3 Wildowed 4 Divorced should be detached for use as ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade complete) COMPLET Elementery/Secondery (0-12) College (1-4 or 5+) CHILD CATE PLUVIDER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) NELL notified at Eroy DEIL BE 19e. INFORMANT'S NAME (Type/Print) 2 HAROSON HMUR pe 20e. METHOD OF DISPOSITION

1 № Burlel 2 □ Cremetion 3 □ Removal from State 20b. PLACE OF DISPOSITION (Name 20c. LOCATION - City must SUITE Donetion 5 C Other (Specify) examiner 21. SIGNATURE OF FUNERAL RETIVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY milist HATTIS. medical 23. PART I. Enfer the diseases, or complications that caused the deeth. Do not enter the mode of dying, such ee cerdiec or reepiratory arrest, Approximate ehock, or haert fallure. List only one ceuse on each line. interval Between 0 Onset and Death IMMEDIATE CAUSE (Final the disease or condition_ resulting in death) other traumatic event, CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If sny, lesding to immediate cause. Enter UNDERLYING ABETES **CAUSE** (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 Injury, PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 | YES 2 | NO shows 1 YES 2 NO 0 PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) Item State OTHER: 1 | YES 2 110 etlent 2 - ER/Outpetlent 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) the 0 28a. OATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d. DESCRIBE HOW INJURY OCCURED marked. With 1 Netural 5 Pending 1 YES 2 NO BY death 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide E HOSPITAL OR ATTEND E FUNERAL DIRECTOR: A J within 72 hours after d RTANT: If Item 28 Is 60 COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE HOSPITAL (
TO THE FUNERAL C
be filed within 72 h
IMPORTANT: If IN 2
MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end in 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE 12 90 2 TESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) HUSSI SAI

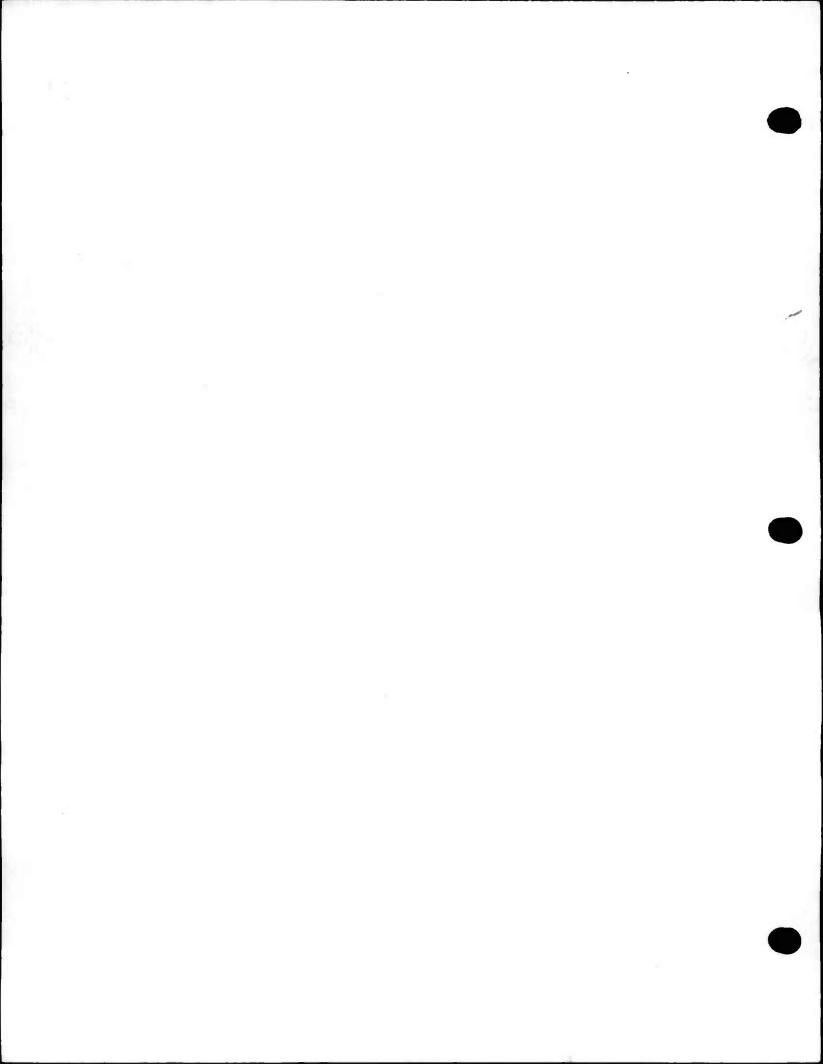
Davidson-Borden

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

REG. NO.

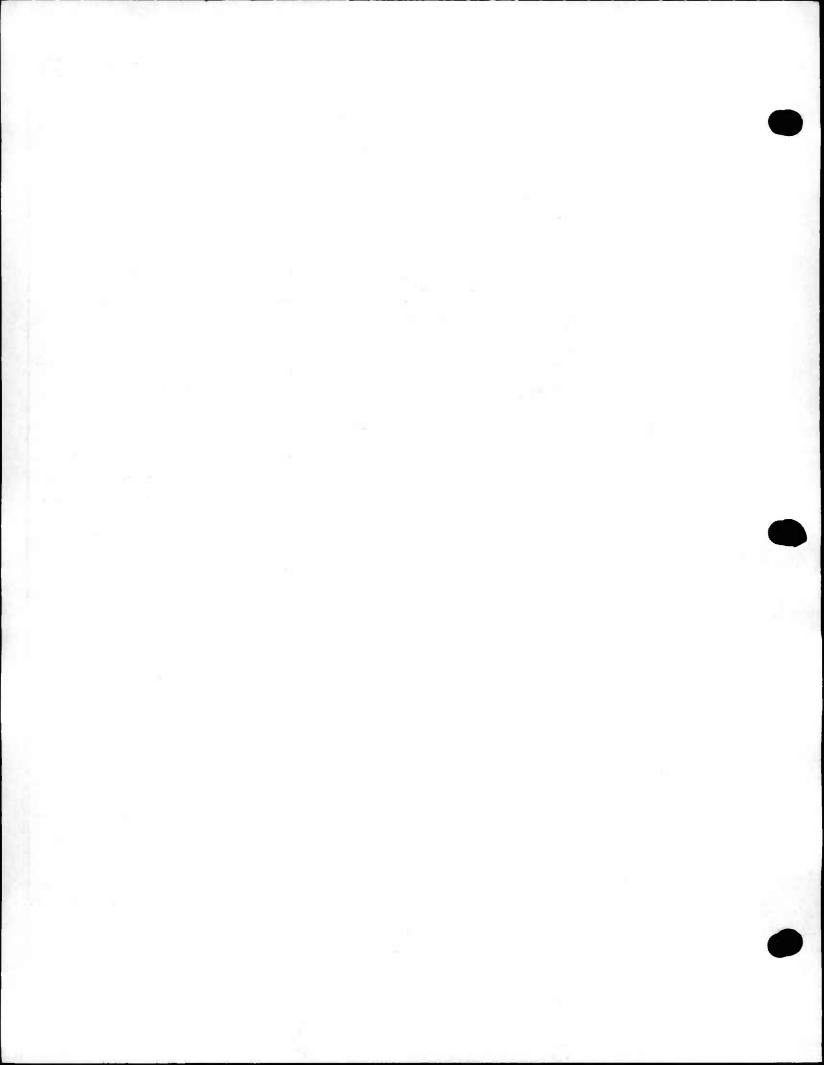
3. TIME OF DEATH

DHMH-16 Ray 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 - nours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | REG. NO. | E | , |
|----------------------|--|---|--|-----------------|-------------------------------|---|------------------|---|
| | DECEDENT'S NAME (First, Middle, Last) DO | AKA: Delo lores S. Smi | | Smith | | 2. DATE OF DEATH DAY | 90 YEA | 3. TIME OF DEATN |
| | The state of the s | 5. SEX 1 | | | HOURS MIN, | 7. DATE OF BIRTH (Month, Day, Year) 6-11-1921 | Co | RTNPLACE (State or Foreign untry) Maryland F DEATH |
| TOR | 7900 Benesch | | | Glen E | | | A | Arundel |
| IREC | 10a. STATE 10b. COUNTY | | | OWN OR LOCATI | | | | 10d. INSIDE CITY LIMITS? |
| AL D | Maryland Anne | Arundel | Glei | n Burni | ZIP CODE | | 10g. CITIZEN C | 1 YES 2 NO |
| BY FUNERAL DIRECTOR | 7900 Benesch C: 11. MARITAL STATUS 1 | ircle Apt. 8 2. WAS DECEDENT EVER IN FORCES? 1 Tyes 1F YES, GIVE WAR OR DAT | U.S. ARMED 2 NO | II yes, spe | | C ORIGIN? (Specify Yee i, Puerto Rican, atc.) | В | ACE — American Indian, lack, White, atc. |
| COMPLETED B | 15. DECEDENT'S EDUCAT (Specify only highest grade con | npleted) | 16a, OECEDENT'S USL (Give kind of work life. Do NOT use re | done during mos | N It of working | 16b. KINO OF BUS | SINESS/INOUSTR | White |
| MPLE | Elementary/Secondery (0-12) (0-12) (0-12) (1-12) | College (1-4 or 5+) | Piece Wo | | | Therm | no Compa | any |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) C1: | arence Andre | ew Irwin | | | ME (First, Middle, Malden san Hemen | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Sandra Wierzbick | i | 195. MAILING AO | | | loute Number, City or Town | | |
| | 20s. METHOD OF DISPOSITION 1 ☑ Burla1 2 ☐ Cremation 3 ☐ Remova | I from State | PLACE OF DISPOSITION Other place) | | | | CATION City o | |
| | 4 Donation 6 Other (Specify) 21. SIGNATURE OF FUNERAL-SERVICE LICEN | | State V | Georg | e J. Gon | ce Funeral | L Home | |
| | 23. PART I. Enter the diseases, or con | | | | | Hwy. Balti | | Approximeta |
| | ahock, or haart fellure. Lis IMMEDIATE CAUSE (Final disease or condition reculting in death) a | Lapra | oly | Arr | est. | | | intarval Between Onset and Deeth |
| TION | Sequentially list conditions, if any, leading to immediate | HOLLOWING ON AS A | CONSEQUENCE OF): | lowe | u Oly | Dirace | e Pu | luency |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | Under | - | |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant conditions of | contributing to death bu | t not resulting in t | | g cause given in | Part I. 24a. WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ICIA | | HOSPITAL: | | 26. PL | ACE OF DEATH (Che | ack only one) | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. fNJ | Besidence URY AT RK? ZES 2 NO | 8 Other (Specify) 28d. OEŞCRIBE HOW I | NJURY OCCURE | 0 |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY building, etc. (Special | A1 home, farm, atre- | | | 281. LOCATION (Street City or Town, State) | end Number or Re | ural Route Number, |
| COMPLETED | one) | AN: To the best of my knowle | | | | | | use(e) and manner ee stated. |
| TO BE | 296 SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ANGRESS OF PERSONS WITH | Attende COMPLETED CAUSE OF DEA | ûs Doc | To | D 2 16 | 84 | 29d. DATE SIG | NED (Month, Dey, Year) |
| | C.V. CYRIAC-1 | 4.0.160 | D CRA | | NY G | LRNB | YRNIB | MD 21061. |
| | DEC 11 1990 | 32. REGISTRADE SIGNA | Mandall . | | , | | | |



рм

FUNERAL DIRECTOR

BY

COMPLETED

BE

2

PHYSICIAN: MEDICAL CERTIFICATION

В

BE COMPLETED

2

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hor | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach | | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notifiled at once, |
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| dea | e att | Лепта | un' |
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| s tha | peu | afth a | an |
| quire | n sig | f He | OWS |
| W re | pee | pt. o | 3 sh |
| he la | s has | e De | m 2 |
| N: T | ficat | Staf | He |
| SICIA | Certi | the | 1, 0 |
| PF | this | with | rke |
| SING | Affer | death | E |
| TEN | OR: | ffer | 8 |
| RAI | RECT | urs a | E 2 |
| 10 | 0 7 | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | f ite |
| SPIT | VERA | 7 nin | ij |
| 9 | E | 1 with | HIA |
| 포 | 五 | filed | PO |
| 2 | 2 | pe | 2 |

| 1 - FOR STATE REGISTRAR | STATE OF I | | | TMENT | | | | MENTAL HYGIEN REG. NO. | _ | | |
|--|--------------------|-----------------------|-------------|---------------|-------------|-------------------|------------|---|--------------|---------------|---|
| 1. DECEDENT'S NAME (First, Middle, Las | ?) | | | | | | | 2. DATE OF DEATH | lv. | | 3. TIME OF DEATH |
| Min | nie | | S | PARK | S | | | December | 07, | 1990 | 2:15 |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | | | IF UNDER | | 7. DATE OF BIRTH | | | LACE (State or Foreign |
| 219-28-4473 | 1 M 2 F | 88 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) 9-9-1902 | | MA i | RYLAND |
| 9a, FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY | , TOWN C | R LOCATI | ON OF DE | EATH | INTY OF DE | | |
| FRANKLIN SQUARE | HOSPITAL | | | | F | ROSSI | /ILL | E | Ва | timo | re County |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUR | TV. | | 100 CI | ry, town o | NR I OCAT | ION | | | | Т | 10d. INSIDE CITY |
| | | | 100. 011 | ii, iomie c | | | IIV. | | | - 1 | LIMITS? |
| MARYLAND E | BALTIMORE | | | | _ | UNDA | | | I 40- 01 | | 1 TYES XX NO |
| | 2210 | | | | 101 | . ZIP COD | | 1000 | iog. Ci | | |
| 7844 ROCKBOURNE | | | | L | | | | 1222 | | 7 | S.A. |
| 11. MARITAL STATUS 1 Never Married 2 Married | FORCES? | | | - 1 1 | If yes, sp | ecify Cubi | in, Maxica | NIC ORIGIN? (Specify Yas an, Puarto Rican, atc.) | n or No— | Black, | American Indian, White, etc. |
| 3XX Wildowed 4 Divorced | IF YES, GIVE | WAR OR DATES | , | | 1 🗌 YES | 2 (1)(0 | Specif | y: | | Specify | WHITE |
| 15. DECEDENT'S El (Specify only highest gre | | 18a. DE | CEDENT'S | Work done | CCUPATIO | ON on of world | | 18b. KIND OF BU | SINESS/IN | IDUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | tit- | . Do NOT | ise retired.) | during mo | IST OF WORK | ny | | | | |
| 8TH GRADE | N/A | | HOM | ME MA | KER | | | | H | OME | |
| 17. FATHER'S NAME (First, Middle, Last) | - | | 111111 | | | 18. MOT | HER'S NA | AME (First, Middle, Maiden | Surname) | | |
| FREDERICK BECK | | | | | | | HEI.1 | ENA WARNS | | | |
| 19a. INFORMANT'S NAME (Type/Print) | <u></u> | 19 | b. MAILIN | G ADDRES | S (Street a | nd Numbe | | Route Number, City or Tox | vn, State, Z | Zip Code) | |
| MARLENE WINTERLI | NG | | 7844 | ROCK | BOUF | RNE F | ROAD | BALTIMOR | E. M | ARYLA | ND 21222 |
| 20a. METHOD OF DISPOSITION 1)(_)(Burial 2 | | 20b. PLACE other p | OF DISPO | SITION (N | ame of ce | metery, cre | metory or | 20c. LC | CATION - | - City or Tov | vn, Stata |
| 4 Donation 8 Other (Specify) | moval from Statu | | | FAT | TH (| P.M. | 12- | -10-90 BA | ITTM | ORF I | MARVIAND |
| 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | | | 22. | NAME A | ND ADDRE | SS OF FA | ACILITY | | • | |
| Format F | Con | Ð | | lν | uva- | •RUCK | (Ful | VERAL HOME | OF 1 | DUNDA. | * |
| | .000 | | - | | | | | ENUE DUNDA | | | 21222 |
| 23. PART I. Enter the diseases, of ahock, or heart failure | | | | not antai | tha mo | da of dy | ing, suc | ch aa cardiac or reap | iretory a | rreat, | Approximata Interval Batw |
| IMMEDIATE CAUSE (Final | | | | | | | | | | | Onset and Da |
| disease or condition resulting in death) | . Acut | e Myocar | dial | Inf | arct | ion | | | | | |
| | | O (OR AS A CONSE | | , | | | | | | | |
| Sequentially list conditions, | | rioscler | | | rt D | isea | se | | | | |
| if any, leading to immediate cause. Enter UNDERLYING | DUE TO | O (OR AS A CONSE | OUENCE | OF): | | | | | | | |

PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Insufficiency

DUE TO (OR AS A CONSEQUENCE OF):

24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 - NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO

Approximata Intarval Batwaan

Onset and Death

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES ZXNO

Diabetes Mellitus

CAUSE (Disease or Injury

that initiated events reaulting in death) LAST

27. MANNER OF DEATH

1XX Natural

2 Accident

3 Sulcide

4 Homicida

HOSPITAL:
1 🂢 Inputiant 2 🗆 ER/Outputiant 3 🗆 DOA OTHER: g Home 5 - Residence 8 - Other (Specify) 4 Nurs 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED

5 Pending investigation 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be

| (Check only | CENTIFYING PRINCIPAL TO the beat of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated |
|-------------|--|
| one) | 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and piece, and due to the |

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year)

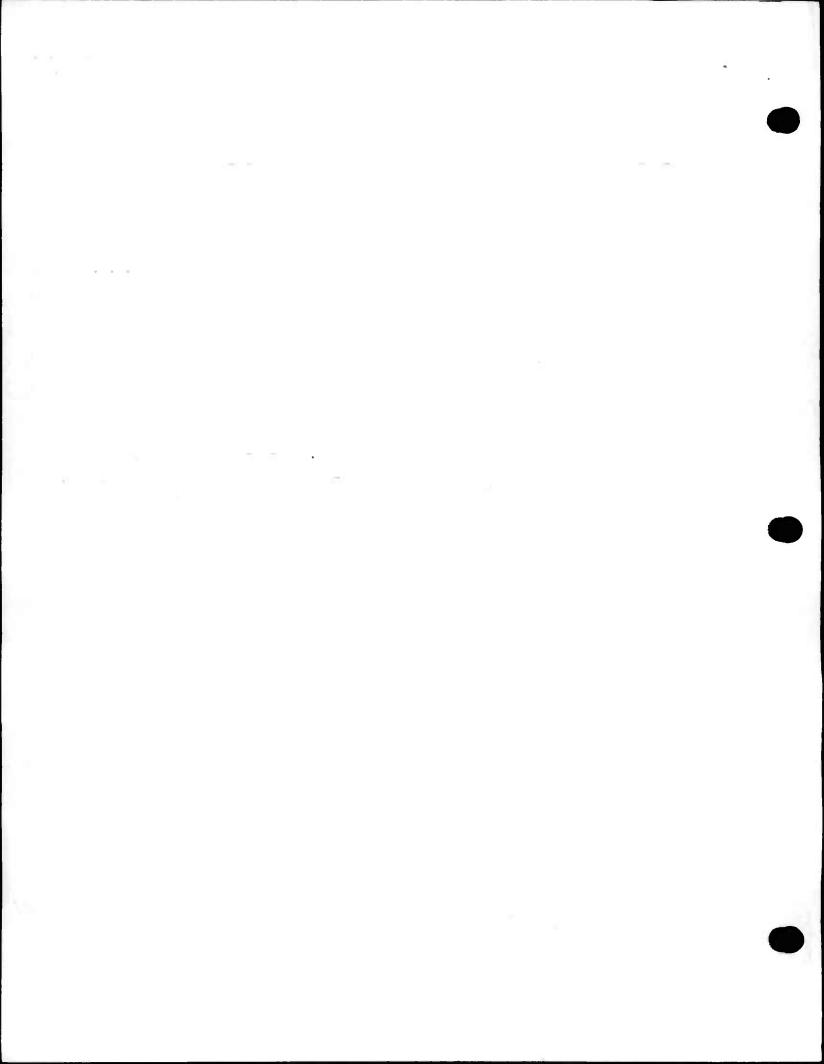
| Kenneth | 1S. | Louis | MI |
|-----------------------------|-----------|----------------------|---------------------|
| D. NAME AND ADDRESS OF PERS | ON WHO CO | MPLETED CAUSE OF DEA | TH (ITEM 27) (Type, |

00305

1 YES 2 NO

26. PLACE OF DEATH (Check only one)





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within XMM attent death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

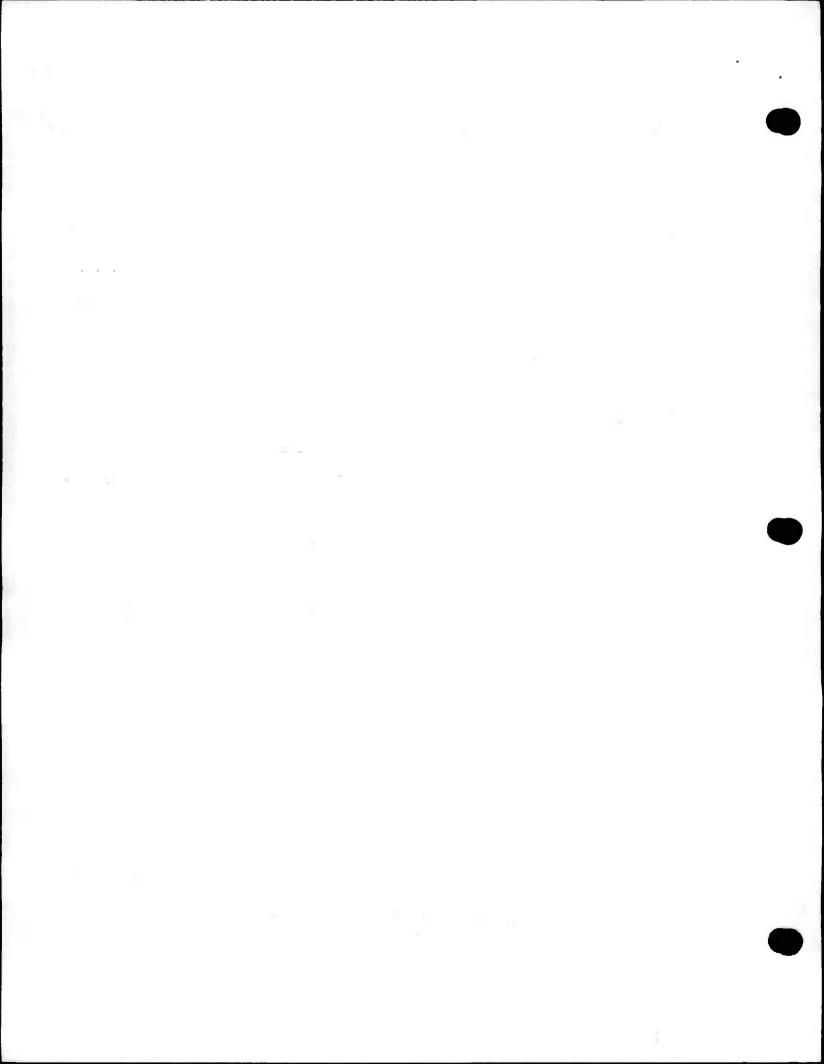
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME | ENTAL HYGIENE |
|---|---------------|
| CERTIFICATE OF DEATH | REG. NO. |

| _ | STRAR | | STATE OF N | ARYLA | | | ENT OF I | | | MENT | AL HYGIEN REG. NO. | E | | 3 | 405 |
|--|---|--|--|-----------------------|--|----------------------------|-------------------------|--------------------------|------------------------------------|-----------------------------|--|-----------------|-----------------------------|--|---|
| 1. DECEDE | NT'S NAME (First, | Middle, Last) | ETHEL | MARIE | STEE | LE | | | | MON | e of DEATH 1 DA | 2/5/ | 90 | | F DEATH 8: |
| 173- | = 14-00 | 85 | 5. SEX 1 M 2 F | 6. AGE (In | yrs. lest birthd | MON | INDER 1 YEAR THS DAYS | IF UNDE | R 24 HRS. MIN. | 7. DAT (Mor | e of BIRTH hth, Day, Year) 22/20 | | Country | v) | te or Foreign JANIA |
| CHUI | | SPITA | treet and number) L CORPO | RATI | ON | 9b. | BALT | | | EATH | | 9c. COU | INTY OF DI | EATH | |
| 100. STATE | | 10b. COUNTY | LTIMORE | | 10c. | сіту, то | WN OR LOCA | TION DUNDA | \LK | | | | | 10d. INSID | DE CITY FS? 2 XXIVO |
| 742 | 1 SCHO | OL AV | | | | | | 1. ZIP COD | 22 | | | | * | u.s.A | ١. |
| | L STATUS r Married 2 wed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2 (00 | | 13. WAS DE- | CENDENT Secify Cub | OF HISPAI en, Mexico Special | NIC ORIG an, Puert y: | iN? (Specify Yea Ricen, etc.) | or No— | 14. RACE Black Specif | — Americ , White, ele fy: WH] | C. |
| | 15, DEC (Specify only stary/Secondary (0 GRADE | EDENT'S EDUC y highest grade 1-12) | CATION completed) College (1-4 or 5- | | | d of work o OT use reti | tione during m red.) | ost of work | ing | =10 | b. KIND OF BUS | | | | |
| 17. FATHER | I'S NAME (First, M EW FRAU! | | N/ A | | f | IUME | MAKET | | THER'S NA | | . Middle, Maiden | HON Surname) | IC | | |
| 19e. INFOR | MANT'S NAME (T | iype/Print) | | | | | RESS (Street | | er or Rural | Route Nu | mber, City or Tow | | | 1222 | |
| 4 🗆 Dona | OD OF DISPOSITE 1 2 Crematic tion 5 Other | (Specify) | | | PLACE OF DIS other place) K LAWN | | METERS | / 12 | -8-1 | 990 | 20c. LO BA | | City or To | | LAND |
| 21. SIGNAT | DA FUNERA | E BERIVICE LIC | ENSEE | | | | | RUCK | FUN | ERA | L HOME DUNDA | | | LK, 1 | |
| IMMEDIA disease | I. Enter the d shock, or h ATE CAUSE (Fir or condition in death) | eart failure. | complications the Liet only ons can a | iae on ea | CA P | C DI | Ae. | | | | | retory si | rreat, | inte | proximate rval Betwee set and Deat |
| if sny, le cause. E CAUSE (I that initial | lelly list condit eding to imme nter UNDERLY Diseese or inju atad avants in deeth) LAS | diate ING iry | c | | | E OF): | SIS HER | AL | VA | Sca | ly In | n f | han | <u> </u> | |
| PART II. | Other eignifice | ent condition | na contributing to | deeth bu | it not result | ing in th | ne underlyli | ng ceuse | given in | Part I. | 24a. WAS AN PERFOI 1 TYES | RMED? | / 24b | COMPLETE DF DEATH | TOPSY FINDINGS E PRIOR TO ION OF CAUSE 17 |
| EXAMI | ASE REFERRED TINER? | O MEDICAL | HOSPITAL: | | | | HER: | PLACE OF | | | | | | | |
| 27. MANNE 1 | er OF DEATH stural 5 | Pending Investigation | 28e. DATE Of (Month, i | FINJURY Day, Year) | | TIME OF | M 1 🗆 | JURY AT ORK? YES 2 | | 28d. D | ESCRIBE HOW | | | Doube Mumb | |
| 3 Sc 4 He | omicide | Could not be determined | building | etc. (Speci | ity) | | | | ce, end du | C | ty or Town, State, |) | | HUNG | |
| (Check one) 29b. SIGNA | | ICAL EXAMINE | ER: On the beele of | | | | | death occ | | e time, d | | nd due lo | | | |
| | M | Sisp | HO COMPLETED CAL | ISE OF DEA | ATH (ITEM 27) | (Type, Prir | nt) | 1 | D | | .75 | > | 12 | 5, | 90 |
| DR. | | JPURI | A 32. 4 Cultin | 1.00. | N. B. | ROAI | YAWC | BAI | LTO. | , N | ID. 2 | 123 | | | |



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MPORTANT: If

2

BALTIMORE, MARYLAND 21203-3146

Pages 1, 2, 3 should

attending physician and completely fintal Hygiene prior to burial, cremation law requires that the death certificate be executed within signed by the atte peen Dept. t HOSPITAL DR ATTENDING PHYSICIAN; The this certificate ha After t DIRECTOR: / FUNERAL 1 within 72 h TO THE H TO THE F be filed w

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATH 12/9/90 3. TIME OF DEATH WILLIAM H. SISK. PLILIPOM 2225 O YEAR SISK, SR. 7. DATE OF BIRTH /19
(Month, Day, Year) /196 BIRTHPLACE (State or Foreign 5. SE) 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS MARYLAND 213-09-6104 89 19 9e. FACILITY NAME (If not institution, give street and number) 9c, COUNTY OF DEATH 9b, CITY, TOWN OR LOCATION OF DEATH BALTIMORE DIRECTOR ST. AGNES HOSPITAL 10c, CITY, TOWN OR LOCATION 10e STATE 10d. INSIDE CITY LIMITS? BALTIMORE CATONSVILLE 1 - YES 2/1 NO MARYLAND FUNERAL 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 405 THACKERY AVENUE 21228 U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES If yee, specify Cuban, Mexicen, Pu

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify: WHITE BY 3 X Widowed 4 ☐ Divorced ETED. 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5 +) COMPL 12 OWNER GROCERY STORE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First Middle Maiden Surname) SILAS BENJAMIN SISK SARAH ALVERTA PHELPS BE 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number City or Town State 7to Code 2 WILLIAM H. SISK, JR. 4038 JAY-EM COURT, ELLICOTT CITY, MARYLAND 21043 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State GOOD SHEPHERD CEMETERY ELLICOTT CITY, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228 23. PART I. Enter the diseases, or complications that caused the deeth. Do not anter the mode of dying, such se cerdisc or respiratory arrest, shock, or heart feliure. List only one cause on each line. intarvai Betwaen Onset and Death **IMMEDIATE CAUSE (Finel** diseese or condition resulting in daeth) - Organ DUE TO (OR AS A CONSEQUENCE OF): Jupsis. CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other algnificant conditions contributing to death but not reculting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL **AVAILABLE PRIOR TO** COMPLETION OF CAUSE 1 - YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 TES 2 NO Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural
2 Accident 1 YES 2 NO BY 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 25s. CENTIFIER CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) end menner ee stated. MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occurred at the time, data and place, and dus to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER Resident 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE

Physician

32. PEGETRA DE PROMISE

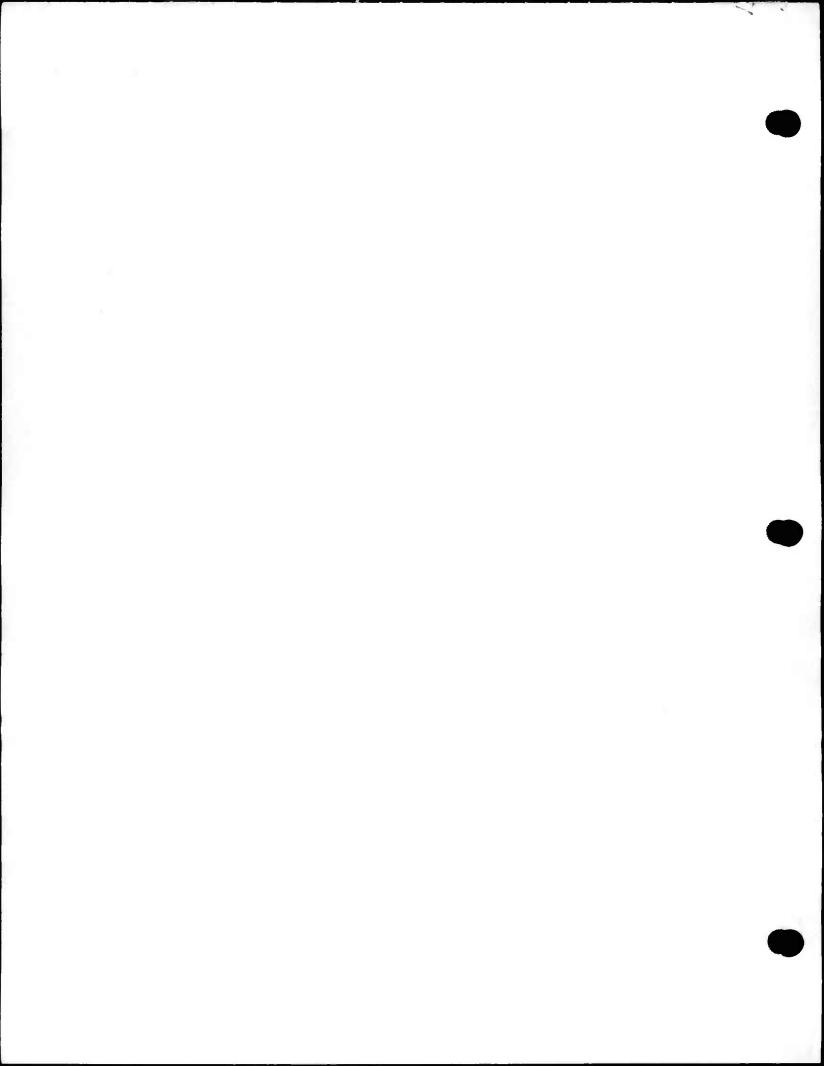
1990

Gmore

MS. 21229.



12/9/90



| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 20 yours after death. Page 6 may be retained by the hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Debt. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death of | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the selection within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or |

| • | | | | | | | 91 | 34058 |
|--------------------|---|--|----------------------|---------------------|----------------------|---|-----------------|--|
| | FOR STATE REGISTRAR | STATE OF MARYLAND | | MENT OF H | | MENTAL HYGIEN | E | |
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Eileen | D | Ter | | | MONTH DA | Y YE | N 340D M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. II | ant hirthday) | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign |
| | 217-07-1018 | 1 - M 2 XF 74 | | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) | 19/6 C | larysville,Md. |
| TOR | 9a. FACILITY NAME (If not institution, give s Shady RESIDENCE OF DECEDENT | rove Adv. | Hisp | ROCK | VILLE | Md. | Mon | OF DEATH |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNT | | | TOWN OR LOCA | FION | | | 10d. INSIDE CITY LIMITS? |
| ā | W.Va. | Mineral | | Keyser | | | | 1-XYES 2 NO |
| A | 10e. STREET AND NUMBER | | | 10 | f. ZIP COOE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 11 | 310 St. Cloud | Street | | | 26726 | | | USA |
| ΞI | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. A | AMED | 13 WAS DEC | | IIC ORIGIN? (Specify Yes | or No. 14 | RACE — American Indian. |
| | 1 Never Married 2 Married | FORCES? 1 YES 2 X | | If yes, sp | ecify Cuban, Mexica | n, Puarto Rican, atc.) | 14. | Black, White, atc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES | NO Specify | | 1 | Specify: |
| | | 1 | | 1 | | White | 1 | White |
| ш | 15. OECEDENT'S EDU (Specify only highest grade | e completed) (| (Give kind of wor | k done during mo | ON ost of working | 18b, KINO OF BUS | SINESS/INDUST | RY |
| ių | Elementary/Secondary (0-12) | College (1-4 or 5+) | fe. Do NOT use r | retired.) | | | | |
| <u>a</u> | Unknown | | Homen | naker | | | Own Ho | ome |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | ME (First, Middle, Malden | Surname) | |
| 0 | John Patric | k Delanev | | | Agnes | s Watson | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | 200000 (0) | | | | |
| 임 | Mr. Robert L. Sut | | | | | Route Number, City or Tow | | 26726 |
| - 1 | 20a. METHOO OF DISPOSITION | 20b. PLAC | E OF DISPOSIT | ION (Name of ce | metery, crematory or | 20c. LO | CATION - City | or Town, Stata |
| | 15 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | over from State other | otomac | Memori | al Garder | ns I | Kevse | er, W.Va. |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | | | ND ADDRESS OF FAI | | 1101 | |
| - 1 | 21. SIGNAL THE OF FUNERAL SERVICE L | | | 22. NAME A | NU ADDRESS OF FAI | CILITY | 85 S | Main St. |
| | All I | V. V | | Rotru | ck Funera | al Home | | |
| | an part I Fee de die | | | | | | | , W.V. 26726 |
| | 23. PART I. Entar the diseases, or shock, or heert failure. | List only one ceuse on each list | daeth. Do noi na. | t enter tha mo | oda of dying, suci | h ae cerdiec or respi | ratory arrest | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | 2 | 1 . | tou | Amost | _ | | Onset and Death |
| | resulting in death) | e. Cayaro ye | EQUENCE OF: | no roj | 1117001 | | | |
| | | 10000 10 | n Li | 000 | la nai. | in Paral | | j |
| CERTIFICATION | Sequentially list conditions, | . curie co | I LY | ernow | ragice | Inforce. | | |
| Ĕ | If eny, lasding to immediate | SWAN DUE TO (OR AS A CONE | EOUENCE OF): | | | U | | |
| 2 | cause, Entar UNDERLYING CAUSE (Disease or Injury | c. Kayana | | | | | | |
| <u>u</u> | that initiated events | TO (OR AS A CONS | EOUENCE OF): | | | | | 1 |
| E | resulting in death) LAST | d. | | | | | | |
| 8 | | | | | | | | |
| 7 | PART II. Other algnificant condition | na contributing to death but not | t resulting in | the undarlyin | g cause given in | Part I. 24a. WAS AN PERFOI | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 5 | | | | | | 1 _ YES : | | COMPLETION OF CAUSE |
| | - | | | | | | 2000 | OF DEATH? |
| Σ | | | | | | | | 1 TYES 2 NO |
| z l | l | | | | | | | |
| 3 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | LACE OF OEATH (Ch | eck only one) | | |
| PHYSICIAN: MEDICAL | 1 TES 2 NO | 1 Nopetiant 2 ER/Outpetiant | | OTHER: | ne 5 🗆 Realdence | 8 Other (Specify) | | |
| 主 | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | OF 28c. IN | JURY AT | 28d. DESCRIBE HOW | NJURY OCCUR | EO |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJUE | RY W | ORK? YES 2 NO | | | |
| BY | Accident investigation | OR DI ACE OF ALKIEV | Samuel Community | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide datarmined | 28e. PLACE OF INJURY — At building, atc. (Specify) | noma, rarm, ath | wat, ractory, offic | C-0 | 28f. LOCATION (Street City or Town, State, | and Number of I | rtura: rioute Number, |
| E | - Indifferent observation | | | | | | | |
| ٦ | 290. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my knowledge, | death occurred | at the time det | and place and due | to the causals) and ma | nner se et-t4 | |
| ¥ | one) | | | | | | | average and many as at the f |
| COMPLETED | - I MEGICAL EXAMIN | ER: On the basis of examination and/o | mivesagation, | at my opinion, | useur occured at the | ume, care end pieca, at | ru qua to tha c | museta) and manner as stated. |
| ш | 296. SIGNATURE AND THE OF CENTRE | 7/ 110 | | | 29c. LICENSE NUM | WBER - | 29d, DATE S | GNED (Month, Day, Year) |
| 8 | 1 ahul sed | (Jun | | | 1224 | 4+ | 1 /2 | 2/06/90 |
| 2 | 20 MARS AND ADDRESS OF DEPENDING | HO COMPLETED CAUSE OF DEATH (I | TENLOT (T | 2-(-4) | | | | 1 1 |

| | | | | 1 □ YES 2⁄QXNO | OF DEATH? 1 YES 2 NO |
|--|--|------------------------|----------------------------------|---|-----------------------|
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF OEATH (CI | heck only one) | |
| | OSPITAL: Unpetiant 2 - ER/Outpetiant 3 | DOA 4 N | ER: ursing Home 5 - Realdence | 8 Other (Specify) | |
| 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCUR | EO |
| 1 Natural 5 Pending Investigation | | М | 1 YES 2 NO | | |
| 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF tNJURY — At hon building, atc. (Specify) | ma, farm, atreat, fa | ctory, office | 281. LOCATION (Street and Number of City or Town, State) | Rural Route Number, |

| 296. SIGNATURE AND TYPLE OF CHITTEEN US | 29c. LICENSE NUMBER D32417 | 29d. DATE SIGNED (Month, Day, Year) 12/06/96 |
|---|-------------------------------|---|
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | 0.1 | 111 3 - 0 - |
| 10620 GEORGIA AVE # 218 | Silver Spring | MD 20902 |

31. DATE FILED (Month, Day, DEC

DHMH-16 Rev 1/89



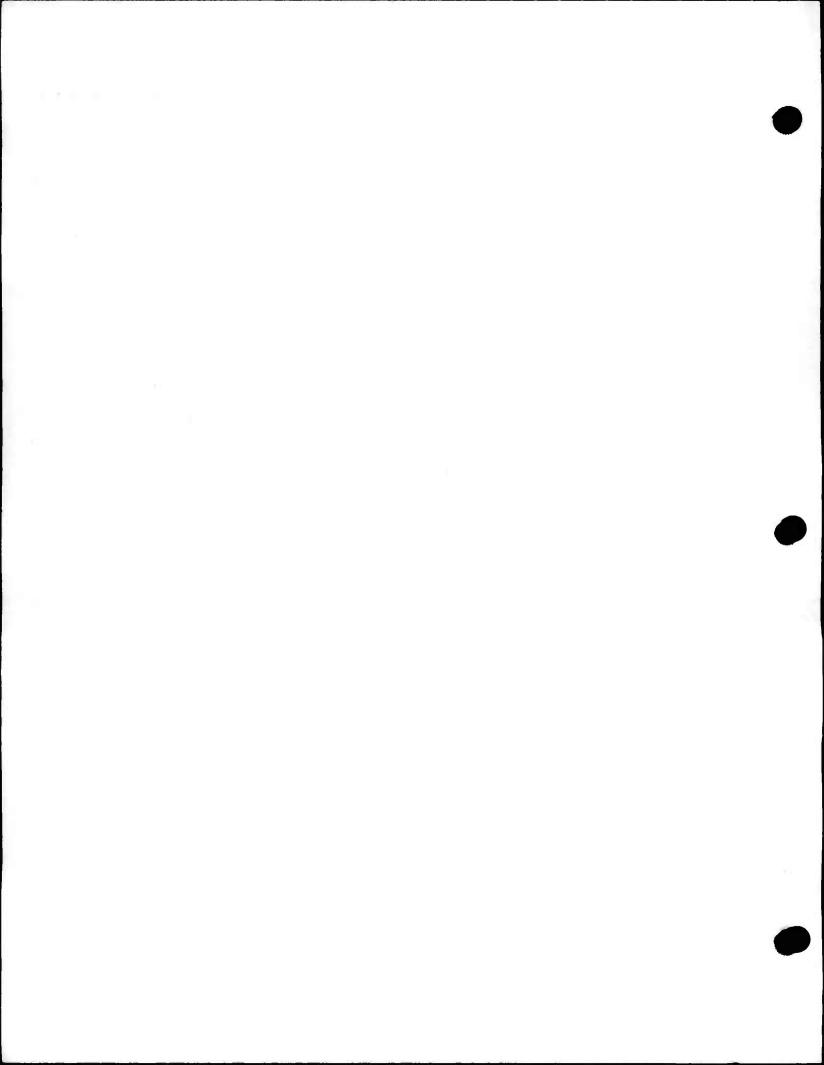
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attending physician and completely filled in by the funeral director, page 5 should be detached for ntal Hygiene prior to burial, cremation, or removal. requires that the death certificate be executed within signed by the atter Health and Mental been : certificate has been the State Dept. of or item 23 s DR ATTENDING PHYSICIAN: The law this c After 1 death DIRECTOR: / FUNERAL (within 72 h HOSPITAL TO THE P TO THE P De filed w

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR **CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH Dec. 10 1990 3:30 A Winchester Simons <u>Fannie</u> 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In vrs. lest birthdev) 8. BIRTHPLACE (State or Foreign 7. DATE OF BIRTH (Month, Day, Year) Aug. 13 DAYS 1 - M 2 X F HOURS 100 YRS. 1890 Maryland 460-05-7257 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore Cockeysville 10704 Westcastle Place RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE 10b. COUNTY 10d. INSIDE CITY Cockeysville 1 YES 2 X NO Baltimore Maryland FUNERAL 10s. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21030 USA 10704 Westcastle Place 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Mexican, Puario Rican, etc.) 1 Never Married 2 Married Specify: White 1 YES 2 NO Specify: BY 3 KWidowed 4 Divorced ETED. 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only higher (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) Balto. Gas & Elec. Co. COMPL Home Service Director 18. MOTHER'S NAME (First, Middle, Maiden Surname) COLECATE NESBIT BROW 17. FATHER'S NAME (First, Middle, Last) -Eolegate Nesbit Brown 듇 Dr. Nathan Ryno Smith notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 10704 Westcastle Place Cockeysville, Md.21030 Fannie H. Cockey must be 20a. METHOD OF DISPOSITION
1 □ ★urial 2 □ Cremetion 3 □ Rem 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State oudon Park Cemetery Baltimore, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MALTIN 22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld Martin D. Lawson Timonium, Maryland 21093 the medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reapiratory errest, shock, or heert fellure. Liet only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition resulting in deeth) event, DUE TO (OR AS A CONSEQUENCE OF): (2) 1 CUM traumatic CERTIFICATION Sequentially liet conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting in deeth) LAST MEDICAL PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuee givan in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 1 YES 2 NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28d, DESCRIBE HOW INJURY OCCURED 28b. TIME OF 28c. INJURY AT WORK? marked, 1 Natural 1 YES 2 NO М BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, fectory, office building, stc. (Specify) 281. LOCATION (Street and Number or Bural Route Number, City or Town, State) 3 Suicide 28 Is COMPLETED 6 Could not be determined 4 Homicide IMPORTANT: If Item 29a, CERTIFIER 1/ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12/10/20 020807 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 120 St. Pierre Dr., Towson, Md. 21204 Benjamin Yorkoff, M.D. 32. REGISTRAR'S SIGNATURE 31. OATE FILED (Month, Day, Year)





HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed

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| ECTOR: After this certificate | s aft | 28 |
| DIR | hours af | item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified |
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90 34060 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) ERNEST 2. DATE OF DEATH MONTH SRNEC (nmn) 11 . 08AM SRNEC 12 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign DAYS HOURS 1 X M 2 - F 214-05-1200 VRS 3-8-1897 Austria 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Harbor Hospital Center Baltimore City Baltimore City 10s. STATE 18c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO Anne Arundel Glen Burnie ERAL 10a STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 102 North Crain Hwy. Apt. 21061 907 U.S.A. FUN 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ♣ NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, Whits, etc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 N Married BY 3 Widowed 4 Divorced White COMPLETED 18s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Collegs (1-4 or 5+) 5th Machinist John's Hopkins University None 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN Srnec UNKNOWN 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mrs. Myrtle H. Srnec Same as 10 20s. METHOD OF DISPOSITION
14 Burisl 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State 4 Donation 5 Other (Specify) Meadowridge Memorial Park Elkridge, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Singleton Funeral Home Agrica 1 Second Ave. S.W. Glen Burnie, Md. 21061 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, interval Between Onset and Death disease or condition resulting in death) Chronic 2-620 CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate ongentive cause, Enter UNDERLYING CAUSE (Disease or Injury DUE TO OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST The was leron ! LONOVOJ) news! PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY MEDICAL COMPLETION OF CAUSE OF DEATH? SEPSIS 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL:
1 Ninpetient 2 ER/Outpetient 3 DOA OTHER: 1 TYES 2 NO 4 - Nursing Nome 8 - Residence 6 - Other (Specify) 28s. DATE OF INJURY (Month, Dey, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident NIAM 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 8 Could not be determined COMPLETED 4 Homicide

29a. CERTIFIER 1 TO CERTIFYING PNYSICIAN: To the bast of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

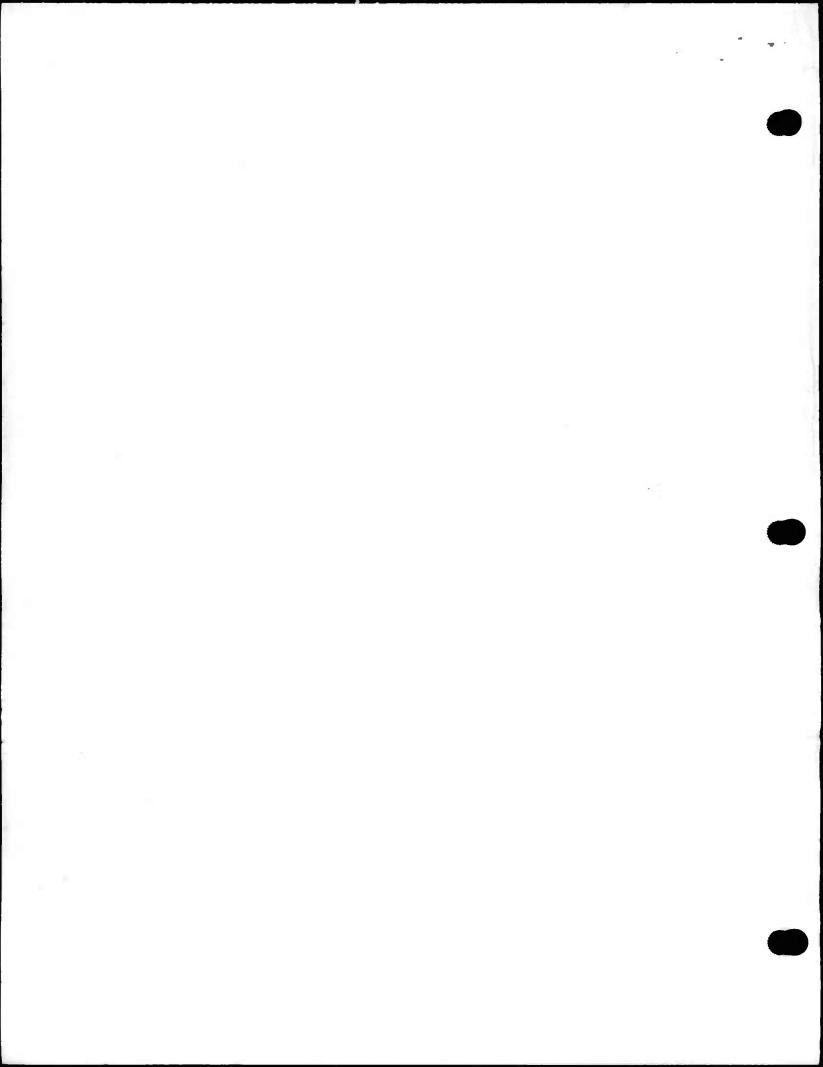
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AS2441614-15 intern . medical 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M HARISH. HARBOR HOSSITAL CENTER. S. HANDUERST. AVVERAHALLI

BALTIMORA MARYLAND

31. DATE FILED (Month, Day, Year) 1990

32. REGISTRAR'S SIGNATURE Savidron Bondalle



TO BE COMPLETED BY FUNERAL DIRECTOR

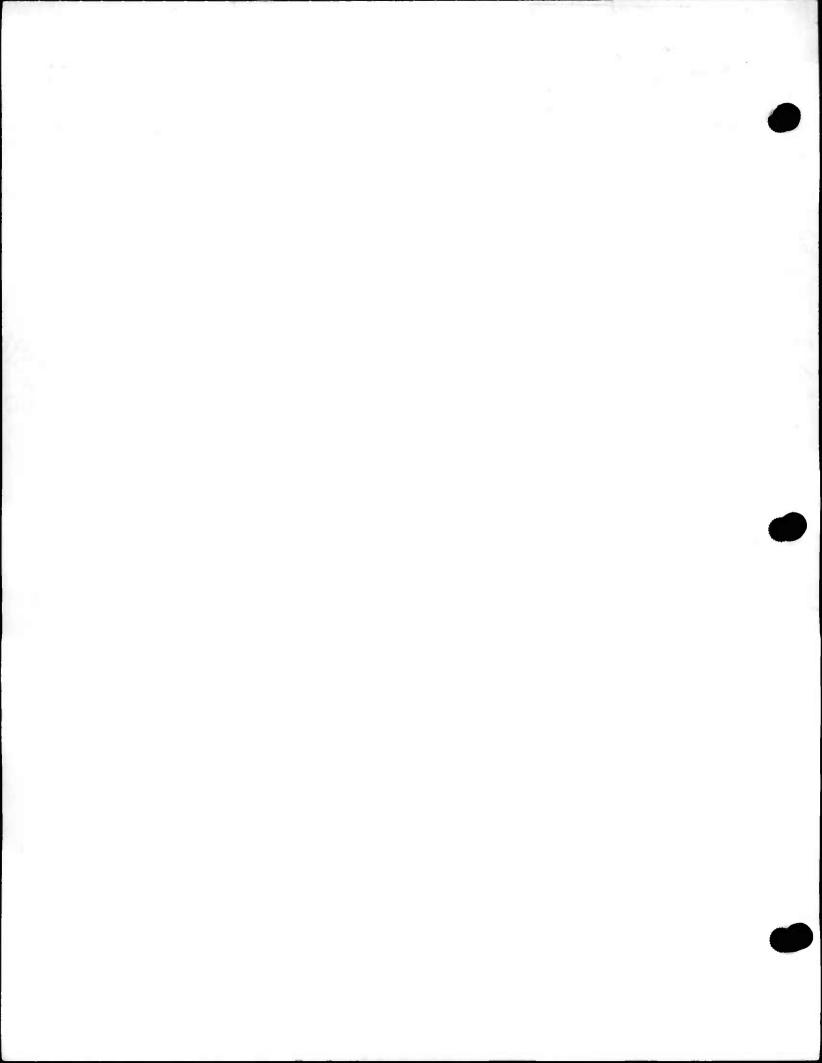
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flows after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be delarched for 1 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | | STATE OF M | ARYLAND | / DEPART | MENT OF | HEALTH AND | MENTA | L HYGIEN | E Ì | 90 | 34001 |
|--|--|--|--|--|--|---|--|--|--|---------------------------------|---|
| 1. DECEDENT'S NAME (First, EVELYN | , Middle, Last) | SKUTCH | | | | | 2. DATE | OF DEATH DA | | YEAR 990 | 3. TIME OF DEATN 3:13 P M |
| 4. SOCIAL SECURITY NUMB 215-10-1910 | | 1 □ M 2 💢 F | 6. AGE (In yrs. 76 | | IF UNDER t YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Mont MAY | OF BIRTH | 14 | 8. BIRTH Count | MARYLAND |
| 9a. FACILITY NAME (If not in THE JOHNS I | HOPKIN | A4100 | TAL | 1 | BALTIM | ORE (| CITY | | 9c. COU | INTY OF C | DEATN |
| MARYLAND | 10h COUNTY | BALTIMORE | | t0c. CITY, | TOWN OR LOC BALT | IMORE | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| 100. STREET AND NUMBER 16 FENCE POS | ST CT. | | | | 1 | 01. ZIP COOE 21208 | | | 10g. CIT | _ | WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 X Widowed 4 Otvo | | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 | | If yes, s | CENDENT OF NISPA specify Cuban, Mexico S 2 XXIO Specific | in, Puerto | | or No— | 14. RAC Blac Spec | E — American Indian, k, White, etc. WHITE |
| | PEDENT'S EDUI y highest grade 9-12) | | | OECEDENT'S U (Give kind of wo life. Do NOT use HOUSE | rk done during n retired.) | TON nost of working | 18 | b, KIND OF BUS | T HO | | |
| 17. FATNER'S NAME (First, M NATHANIEI | 7 7.4: 1 | GAL | | | | 18. MOTNER'S NA | | | Surname) | | |
| 19a. INFORMANT'S NAME (7 MRS. TERRI (| | G | 220 | | | and Number or Rural | | PPERCO, | | p Code) 211 | 55 |
| 20e. METNOD OF DISPOSIT 1 □ Burlal 2X Crematic 4 □ Donation 5 □ Other | on 3 🗆 Rem | oval from State | 20b. PLA othe GF | CE OF DISPOSI P PISCO REEN MO | TION (Name of c UNT | emetery, crematory or | | | CATION — LT'IM | - | |
| 21. SIGNATURE OF FUNERA | L SERVICE LIE | tt llua | | | S | AND ADDRESS OF FA | CILITY & | BROS. | , IN | c. | |
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32. PHIGISTRAN'S SIGNATURE PUNCHER



FOR STATE REGISTRAR

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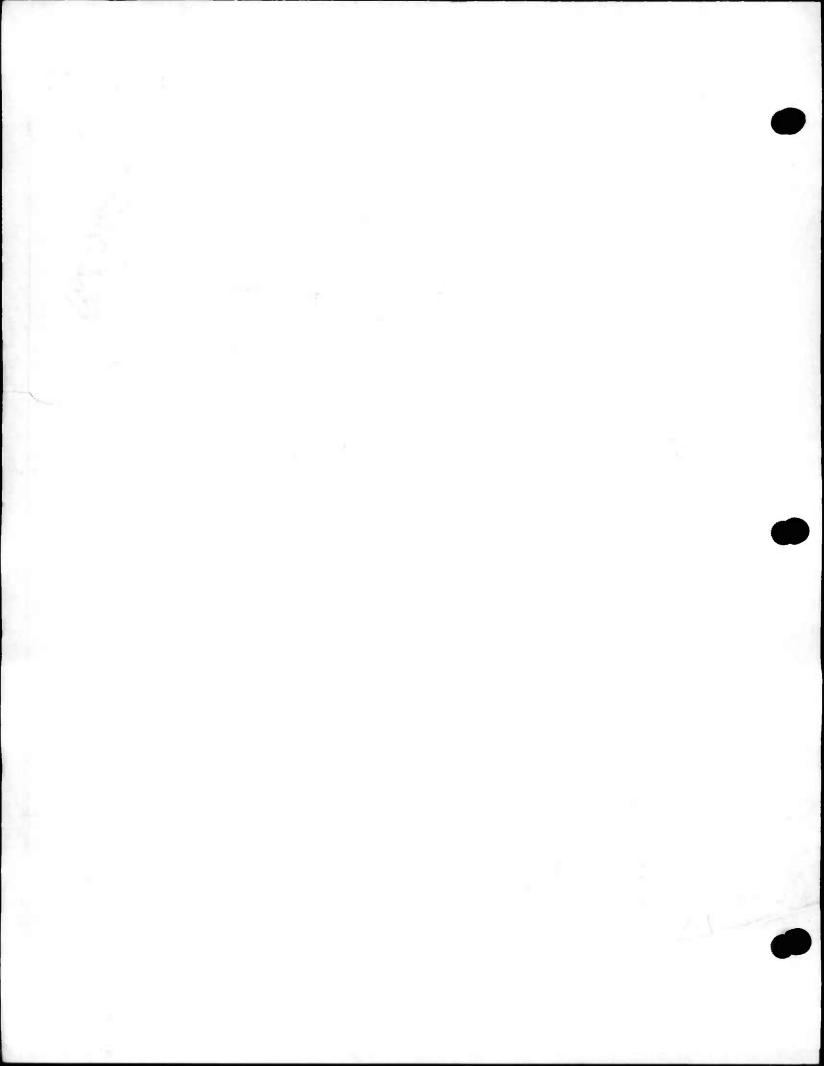
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DIVISION OF VITAL

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2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF OEATN YEAR EILEEN LILLIAN STANLEY 12-5-90 10:30AM 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 6. AGE (in yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. -78-5522 MARYLAND 9e, FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH UNIVERSITY HOSPITAL DIRECTOR BALTIMORE CITY RESIDENCE OF DECEDENT 10d. INSIDE CITY 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION BAIHMETE YES 2 NO BYFUNERAL 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? STREET HUNDE ISA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARNED 11. MARITAL STATUS 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 If yes, specify Cube Never Merried 2 Merried BIACK Specify. 3 Widowed 4 Divorced COMPLETED 18a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INOUSTRY (Specify only highest grade VISILA ASST Elementary/Secondary (0-12) College (1-4 or 5+) Child be notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden FDUUAND STANLE IARMELIHA BE 19e. INFORMANT'S NAME (Type/Print) 5 23 2 WARD 517.80,7 METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cer 20c. LOCATION - City or Town, Stata examiner must uriel 2 Cremation 3 Ren nution 6 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Meal or removal. medical Approximate 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or raspiratory arrest, shock, or heart failure. List only one cause on each ilne. interval Between **Onset and Death IMMEDIATE CAUSE (Final** cremation, other traumatic event, the disease or condition resulting in desth) . SEIZURE DISORDER WITH COMPLICATIONS DUE TO (OR AS A CONSEQUENCE OF): burial, (CERTIFICATION Sequentieily list conditions, DUE TO (OR AS A CONSEQUENCE OF): 2 if any, leading to immediate cause. Enter UNDERLYING Drior **CAUSE** (Disease or injury Hygiene DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, or Menta 24s. WAS AN AUTOPSY PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS MEDICAL **AMILABLE PRIOR TO** Health and amy YES 2 NO COMPLETION OF CAUSE OF DEATN? s certificate has been signed ith the State Dept. of Health 3d, or Item 23 shows an XX YES 2 - NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) E HOSPITAL DR ATTENDING PHYSICIAN: The E FUNERAL DIRECTOR: After this certificate d within 72 hours after death with the State RTANT: If Item 28 is marked, or Item HOSPITAL:
1 | Inpatient XX ER/Outpatient 3 | DOA OTHER: XXXES 2 NO ng Home 5 - Residence 8 - Other (Specify) 4 I Nurs 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. OE\$CRIBE NOW INJURY OCCURED 1 🔣 Natural 5 Pending Investigati 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be determined 4 🗌 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated. MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) and menner as stated. TO THE HOSPITA
TO THE FUNERA
De filed within 77
IMPORTANT: It 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE OCME 12-6-90 9 PLETED CAUSE-OF DEATH (ITEM 27) (Type, Print) ANN M. DIXON, MD 111 Penn Street, Baltimore, MD 21201 Sina Pardson-Handelle 31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



int. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burn be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

30. NAME AND AGORESS OF ROBERT

| | 1-31-91 FilmG671 W.H. Per | · F/H | | | | |
|---------------------------------|--|--|---|--|--|--|
| | FOR 1 - STATE REGISTRAR | | PARTMENT OF HEALTH AND TIFICATE OF DEATH | MENTAL HYGIENI REG. NO. | 90 | 34063 |
| | 1. OECEOENT'S NAME (First, Middle, Last) | | 1 4 | 2. DATE OF DEATH MONTH DA | YEAR | 3. TIME OF DEATH |
| | Sembly Cla | atthce R. Semi | 5/4 | 12 | 9 90 | 10:10 Am |
| | | SEX 6. AGE (In yrs. lest birth | | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIR' | THPLACE (State or Foreign |
| | ZZ0035831 1 | M20F 83 Y | TRS. MONTHS DAYS HOURS MIN. | (Month, Day, 18al) | 57 M | ARUISO |
| | 9a. FACILITY NAME (If not institution, give street | and number) | 96. CITY, TOWN OR LOCATION OF | DEATH | 9c. COUNTY OF | DEATH |
| Œ | LOCH RAVEN | UA HOSPIT | Baltimoi | E | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | |
| H | 10a. STATE 10b. COUNTY | | e. CITY, TOWN OR LOCATION | | | 10d. INSIDE CITY |
| | | FIRE E | LUTHERUITIE | | | 1 VES 2 NO |
| AL | 10a. STREET AND NUMBER | NAMY AUGI | 10f, ZIP CODE | 0 - | 10g. CITIZEN OF | WHAT COUNTRY? |
| 8 | 517 W. SEMI | NAVY HUST | 210 | 73 | 1151 | F |
| FUNERAL | | . WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO | 13. WAS DECENDENT OF HISP If yes, specify Cutan, Mex | ANIC ORIGIN? (Specify Yea | or No- 14. RA | CE — American Indian, ick, White, atc. |
| | 1 Never Married 2 Married | IF YES, GIVE WAR OR DATES | 1 ☐ YES 2 ☐ NO Spe | | | |
| В | 3 Widowed 4 Olivbroad | WWI | | | | Black |
| COMPLETED | 15. DECEDENT'S EDUCATE (Specify only highest grade con | noleted) (Give ki | ENT'S USUAL OCCUPATION ind of work done during most of working | 16b. KINO OF BUS | INESS/INOUSTRY | |
| Щ | Elementary/Secondary (0-12) | College (1-4 or 5+) | NOT use retired.) | | | |
| MP. | | ///is | 1009131 | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER'S | NAME (First, Middle, Maiden | Sumame) | |
| BE (| EDWARD DE | MBLY | FRAZ | CES SET | nBLY | - (|
| | 19a, INFORMANT'S NAME (Type/Print) | 19b. MA | AILING ADDRESS (Street and Number or Rur | / | | 1101013 |
| 2 | LOWISE JEME | 24 3 | 17 W. SEMINA | y me L | OFTHE | Ille, mo |
| | 20a. METHOD OF DISPOSITION 1. Burial 2 Cremation 3 Remova | 20b. PLACE OF Cother place) | DISPOSITION (Name of cemetery, crematory of | 20c. () | wings Mil | ls, MD. |
| | 4 Donation 5 Other (Specify) | | ON FOREST UA CO | nekly las | 1100 | 44 TH 189 1/24 |
| | 21, SIGNATURE OF FUNERAL SERVICE LICEN | SEE/ | 22. NAME AND ADDRESS OF | FACILITY | 1701 | Inclusion S |
| | 1 Des such | farme | Will MAN. | Homes FU | 12014 | ine now |
| - | 100/11 | | (A111) 1/1110 | | 134111 | There, The |
| | | plicetions that caused the deeth. | . Do not enter the mode of dving, s | uch es cerdiac or respi | retory erreat. | Approximate |
| | | t only one cause on each line. | | Service Transfer Transfer | | Interval Between |
| | immediate cause (Final | | 1 1 51 | | | |
| | shock, or heart failure. Lis | | heart failure | | | Interval Between |
| | ihock, or heeft fallure. Lis IMMEDIATE CAUSE (Final disease or condition | cohgestive | heart failule | · · | oran • upateur | Interval Between |
| Z | immediate Cause (Final disease or condition resulting in death) | COMPESTIVE DUE TO (ON AS A CONSEQUENTIAL CONSEQUENTIAL CONTRACTOR | heart failule fever, antic il | s ufficience | 4. | Interval Between |
| TION | immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | cohgestive | heart failule fever, antic il | s ufficience | d) | Interval Between |
| ICATION | immediate cause, or heeft failure. Lis immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUER | heart failule her fever, antic il | s ufficience | J) | Interval Between |
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| | shock, or heeft failure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) | heart failule tever, autic il nce of: nce of: | FUTTICIENCE | AUTOPSY : | Interval Between Onset and Death Death ANALABLE PRIOR TO |
| | immediate cause. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) | heart failule tever, autic il nce of: nce of: | FUTTICIENCE | AUTOPSY : | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | immediate cause. Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) | heart failule tever, autic il nce of: nce of: | FUTTICIENCE | AUTOPSY : | Interval Between Onset and Death Dea |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other significent conditions of | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) | heart failule NCE OF: NCE OF): Ithing in the underlying cause given | In Pert I. 24a. WAS AN PERFOI | AUTOPSY : | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other significent conditions of the cause. Examiner? | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) CONTributing to death but not results COSPITAL: | heart failule NCE OF): NCE OF): Itting in the underlying cause given 26. PLACE OF OEATH OTHER: | In Pert I. 24a. WAS AN PERFOI | AUTOPSY : | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST PART II. Other significent conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) CONTributing to death but not result (OSPITAL: | NCE OF): 26. PLACE OF OEATH OTHER: DOA 4 Nursing Home 5 Residen | In Pert I. 24a, WAS AN PERFOI 1 YES : | AUTOPSY : | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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| D BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST PART II. Other significent conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST PART II. Other significent conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) CONTributing to death but not result of the contribution of t | NCE OF): Compared to the content of the content | In Pert I. 24a, WAS AN PERFOI 1 YES : | AUTOPSY IMED? | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST PART II. Other significent conditions of the conditions of the cause. Examiner? 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OEATH 1 Netural 5 Pending Investigation | OUE TO (OR AS A CONSEQUE) | NCE OF): Compared to the content of the content | In Pert I. 24a. WAS AN PERFOI 1 YES : Check only one) 28d. DESCRIBE HOW 28d. LOCATION (Street | AUTOPSY IMED? | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| D BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST PART II. Other significent conditions of the cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events reaulting in deeth) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Natural 5 Pending Investigation 3 Suicide a Could not be detarmined | DUE TO (OR AS A CONSEQUENT OF TO (OR AS A CONSEQUENT) DUE TO (OR AS A CONSEQUENT) OUE TO (OR AS A CONSEQUENT) OUE TO (OR AS A CONSEQUENT) CONTributing to death but not result of the contribution of the | NCE OF): Compared to the content of the content | In Pert I. 24a, WAS AN PERFOI 1 YES : Check only one) 28d. Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) | AUTOPSY IMED? | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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| COMPLETED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST PART II. Other significent conditions of the conditions of th | DUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) OUE TO (OR AS A CONSEQUE) CONTributing to death but not resu CONTRIBUTED TO INJURY (Month, Day, Flat) 28a. DATE OF INJURY (Month, Day, Flat) 28b. PLACE OF INJURY — Al home, building, etc. (Specify) | NCE OF: 26. PLACE OF OEATH DOA 4 Nursing Home 5 Resident Bb. TIME OF NURY AT WORK? 1 YES 2 NO farm, street, fectory, office | In Pert I. 24s. WAS AN PERFOI 1 TYES: Check only one) as a Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State) | AUTOPSY IMED? NJURY OCCURED and Number or Rur nner as stated. | Interval Between Onset and Death 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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Hospita

32. REGISTRAR'S SIGNATURE Julia Davidson-Randale.

Jabbhover

DHMH-16 Rev 1/89

11:

| BALTIMORE, MARYLAND 21203-3146 | YSICIAN: The law requires that the death certificate be executed within and us after death. Page 6 may be retained by the hospital or attending physician. | is conflicate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | I, OI TEMOVAII. | e medical examiner must be notified at once. |
|-----------------------------------|--|---|---|---|
| OF VITAL RECORDS, P.O. BOX 13146, | w requires that the death certificate be executed within | been signed by the attending physician and completely fille | Ith the State Dept. of health and Mental hygiene prior to bunda, cremation, or removal. | ed, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| OF VITAL | PHYSICIAN: The lan | this certificate has | with the state bep | rked, or item 23 |
| NOSMIG | TO THE MOSPITAE DR. AUTONONG | TO THE FUNERAL PORGETOR Affer | be filed within a houng any cealin | IMPORTANT # 100m 28 Is may |

5 Pending Investigation

6 Could not be determined

1 Natural

2 Accident

3 Suicide

4 Homicide

BE COMPLETED BY

9

| | FOR 1 - STATE | | STATE OF I | MARYLAND | | | | | | | | 9 | 0 | 34064 |
|---------------|--|---------------------|---------------------------------------|--------------------|------------------------------|---|---------------|-------------------|-------------|--------------------------------------|---------------|---------------|--------------------------------|--|
| | REGISTRAR | Address of the sale | | | ERTIF | ICAII | E OF | DEA | IH_ | | EG. NO. | | | |
| | 1. DECEDENT'S NAME (First, | | | | | | | | | 2. DATE OF E | DAY | | EAR | . TIME OF DEATH |
| | Massey 4. SOCIAL SECURITY NUMBER | Taylo | 5. SEX | | | | | | | Decem | | / | _ | 3:30 P |
| | 248-34-374 | | 5. SEX 1 M 2 □ F | 6. AGE (In yrs. 16 | MONTHS DAVE HOUSE MIN (Mont) | | | | | |) – 26 | 6. | Country) | ACE (State or Foreign |
| | 9e. FACILITY NAME (If not in | stitution, give : | street and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | тн | | | |
| 8 | | | neral Hos | spital | | | Ba l t | imor | e Ci | ty | | | | |
| 5 | RESIDENCE OF DEC | 10b. COUNT | | | I 40: 00 | THE THREE PARTY | 00.1001 | | | | | | | |
| DIRECTOR | 2479 | | | | | | or Locat | | | | | | | Od. INSIDE CITY LIMITS? YES 2 \(\text{I}\) NO |
| 4 | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | E | | | 10g. CITIZEN | OF WH | AT COUNTRY? |
| E | 2504 W. B | altin | nore St | | | 21223 US | | | | USA | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, OIVE WAR OR DATES | | | | | 13. | If yes, sp | ecify_Cub | | NIC ORIGIN? (Sen, Puerlo Ricar y: | | r No 14. | RACE - Black, \ Specify: | American Indian, White, atc. Black |
| | 15. DEC | EDENT'S EDU | JCATION e completed) | 16a. 0 | ECEDENT'S | S USUAL C | CCUPATIO | ON set of work | lace | 16b, KIN | D OF BUSIN | ESS/INDUS | TRY | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 a b o r o | | | | | ise retired.) | training inc | of Or Work | riy | Co | ncre | te | | |
| N N | 17. FATHER'S NAME (First, M | firirlia (ast) | - | | I D O I | | | 16 MOT | NA S'GBH | ME (First, Middl | a Maidan Su | imame) | | |
| BE CO | Frazier Taylor Ada Bail | | | | | | | | | | arranoy. | | | |
| | 19a. INFORMANT'S NAME (| Type/Print) | | 1 | 9b. MAILIN | G ADDRES | S (Street a | ind Numbe | er or Rural | Route Number, C | City or Town, | State, Zip Co | de) | |
| 2 | Mattie B. Taylor 2504 W. Baltimore St. | | | | | | | St., | Balt | o M | D. | 21223 | | |
| | 20s. METHOD OF DISPOSITION 1 Disposition 20b. PLACE OF DISPOSITION 20b. PLACE Of DISPOSITION 20ther place) | | | | | | iame of ce | metery, cre | matory or | | 20c. LOCA | TION - City | or Town | ı, State |
| | 4 Donation 5 Other | | CENSEF | | <u> </u> | | | | | | L UW1 | ngs | Mil | 1s. MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Joseph H. Brown Jr. Funeral Home 1913 W. Baltimore St., Balto., MD. | | | | | | | | | | | | | |
| | 23. PART I. Enter the d shock, or h IMMEDIATE CAUSE (Fil | eart fallure. | complications the List only one ca | | | not ente | r the mo | de of d | ing, suc | h ss csrdlac | or respira | tory arrea | t, | Approximate interval Between Onset and Dea |
| | disease or condition resulting in dasth) | → 1 | Metastati | | | | cino | id C | arci | noma Ei | nd St | age | | |
| | | | DUE TO | OR AS A CONS | EOUENCE (| OF): | | | | | | | | |
| CERTIFICATION | Sequentisity list condit if any, lesding to imme | diste | b | OR AS A CONS | EOUENCE (| DF): | | | | | | | | |
| S | cause. Entar UNDERLY CAUSE (Disease or inju | | C. DUE T | O (OR AS A CONS | FOURNOE A | DE: | | | | | | | | + |
| RTIF | that initiated events resulting in death) LAS | эт | d | O (OR AS A CONS | EODENCE | Jr); | | | | | | | | |
| 2 | PART II. Other algorifica | ant conditio | ne contributing to | don'th but not | | In the s | and outside | | aluan In | Dord I of | . WAS AN AI | ITOBOV | I 045 W | WEDE ALIZODOV ENIDOLO |
| ₽ S | PART II, Other algumics | ant conditio | ms contributing to | destribut not | resulting | in that u | inderiyin | g csuse | given in | Part I. 244 | PERFORM | | 1 | VERE AUTOPSY FINDING WAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICA | | | | | | | | | | 1 | YES 2 | NO | | OF DEATH? |
| | | | | | | | | | | - | | | 1 | YES 2 NO |
| AN | 25. WAS CASE REFERRED T | O MEDICAL | | | | | 26. P | LACE OF | DEATH (C) | heck only one) | | | | |
| SICIAN: | EXAMINER? | | HOSPITAL: | FR/Os/trettent | 3 🗍 DOA | OTHE | R: | | | 8 Other (S) | nanifu) | | | |
| PHYS | 27. MANNER OF DEATH | | 28e. DATE O | F INJURY | 28b. TI | ME OF | | JURY AT | -caruerica | 28d. DESCRI | | JURY OCCUI | RED | |
| 0 | 1 Natural 5 | Pending | (Month, | Day, Year) | 11 | JURY | W | ORK? | □ NO | | | | | |

29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, data and piece, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

28s. PLACE OF INJURY — At home, term, street, factory, office building, atc. (Specify)

М

1 YES 2 NO

28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29b, SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIONED (Month, Day, Year) 29c, LICENSE NUMBER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print

Pierre 31. DATE FILED (Mod)

About Rapi Mi General Hospital

OHMH-16 Rev 1/89



| | | | -23 |
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FOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygleine prior to bunal, cremation, or removal.

IMPORTABLY: If item 28 is marked, or item 23 shows any Inlury, or other traumatic event, the medical examiner must be notified at once.

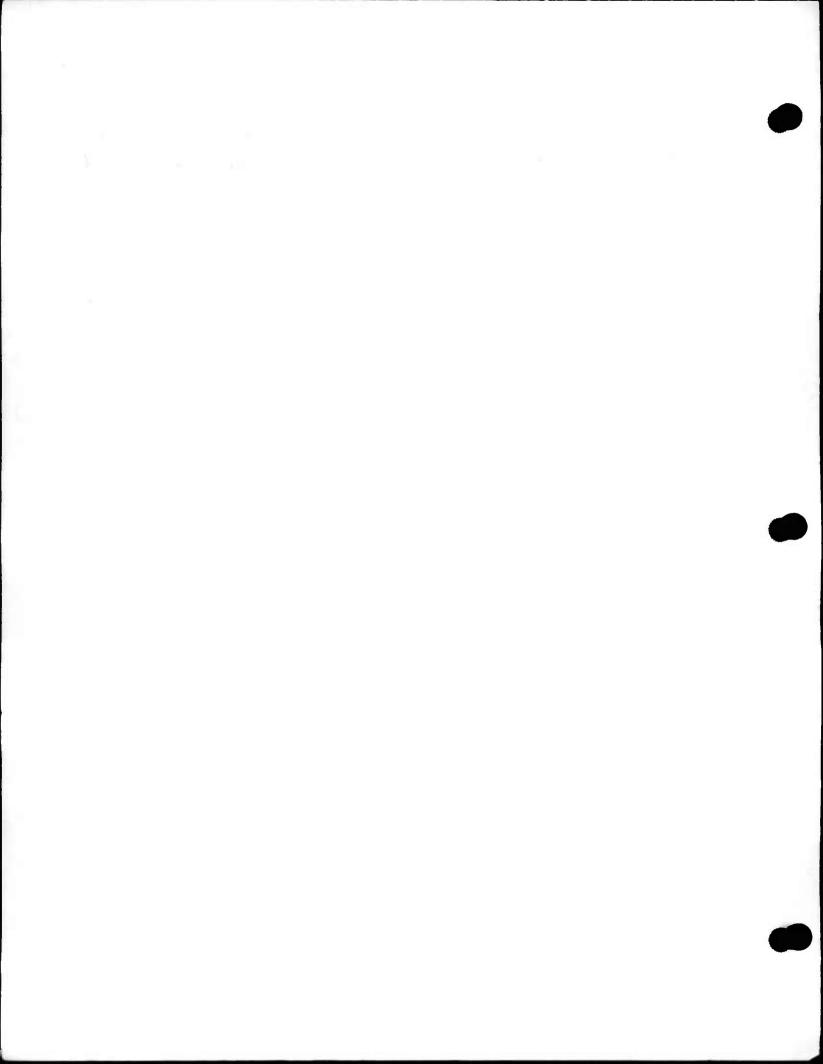
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07

| | 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH | 3. TIME OF DEATH | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|--|
| | Eric Townes/ERIC B. Townes 12 07 % | | | | | | | | | |
| | A SOCIAL SECIENTY MIMBER S. SEY SAGE /In use led blobdow is INDER 4 VEAD SEINDER 24 USE 7 DATE OF BISTYLL S. D. | IRTHPLACE (State or Foreign | | | | | | | | |
| | 213-86-8866 1 KM 2 - F 24 YRS. MONTHS DAYS HOURS MIN. 2-15-66 Country MC | | | | | | | | | |
| E E | 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY O | DF DEATH | | | | | | | | |
| 18 | RESIDENCE OF DECEDENT | | | | | | | | | |
| DIRECTOR | MD 100. STATE 100. COUNTY 100. CITY, TOWN OR LOCATION BALTIMORE, CITY | 10d. INSIDE CITY VIGNITS? 1 X YES 2 NO | | | | | | | | |
| FUNERAL | Too. STREET AND NUMBER 3741 LYNDALE AVE. 109. CITIZEN 21213 | S A | | | | | | | | |
| 11. MARITAL STATUS 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 | | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) 1 2 t h 15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SOIL SAFE I | - | | | | | | | | |
| Į Į | Tr. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Meiden Sumerne) | | | | | | | | | |
| BE CC | | | | | | | | | | |
| P B | | | | | | | | | | |
| | 20s. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or 20c. LOCATION — City of | or Town, State | | | | | | | | |
| | 4 Donation 5 Other (Specify) BALTIMURE CEMETERY BALTIMURI | E, MU. | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22, NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | WM.C. MARCH F.H. 1101 E. | NORTH AVE. | | | | | | | | |
| | 23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, | Approximete | | | | | | | | |
| | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) a. Cardiovascular Arrest / Heurt Furline DUE TO (OR AS A CONSEQUENCE OF): | interval Between Onset and Death | | | | | | | | |
| 7 | | | | | | | | | | |
| TIO | Sequentially list conditions, if smy, leading to immediate Due TO (OR AS A CONSCOUENCE OF): | | | | | | | | | |
| CERTIFICATION | If sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events Due to (or as a consequence of): | | | | | | | | | |
| | resulting in desth) LAST | | | | | | | | | |
| | | | | | | | | | | |
| EDICAL | PART II. Other algnificent conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 24e. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | |
| ĕ | 1 TES 2 NO | OF DEATH? | | | | | | | | |
| Σ | \(\bar{2}\) | 1 TES 2 NO | | | | | | | | |
| Ë | ž . | | | | | | | | | |
| ं हे | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
| Z S | 1 YES 2 NO Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| PHYSICIAN: | | 16 cement slab | | | | | | | | |
| M M | 27 Accident Property of the Pr | | | | | | | | | |
| TED | Ul 4 Homicide determined determined | ML | | | | | | | | |
| PL | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. | | | | | | | | | |
| COMPLET | one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ce | | | | | | | | | |
| E H | 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 298. SIGNATURE AND TITLE OF GERTIFIER 298. SIGNATURE AND TITLE OF GERTIFIER 298. SIGNATURE AND TITLE OF GERTIFIER 299. LICENSE NUMBER | SHED (Month, Day, Year) | | | | | | | | |
| <u></u> 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | David B. Cohen, MD 601 N. Walse St Balto, Md | | | | | | | | | |
| 1 | 31. DATE FILED (Month, D _{BY} , Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |

Julia Davidson-Randelle

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



permit. Pages 1, 2, 3 should

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans. In sind within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| ATTENDING PHYSICIAN: The law requires that the dea | ECTOR: After this certificate has been signed by the at a stree death with the State Deot. of Health and Ment. | 1 28 is marked, or item 23 shows any injury, |
| TO THE HOSPITAL OR | TO THE FUNERAL DIRE | IMPORTANT: If Item |

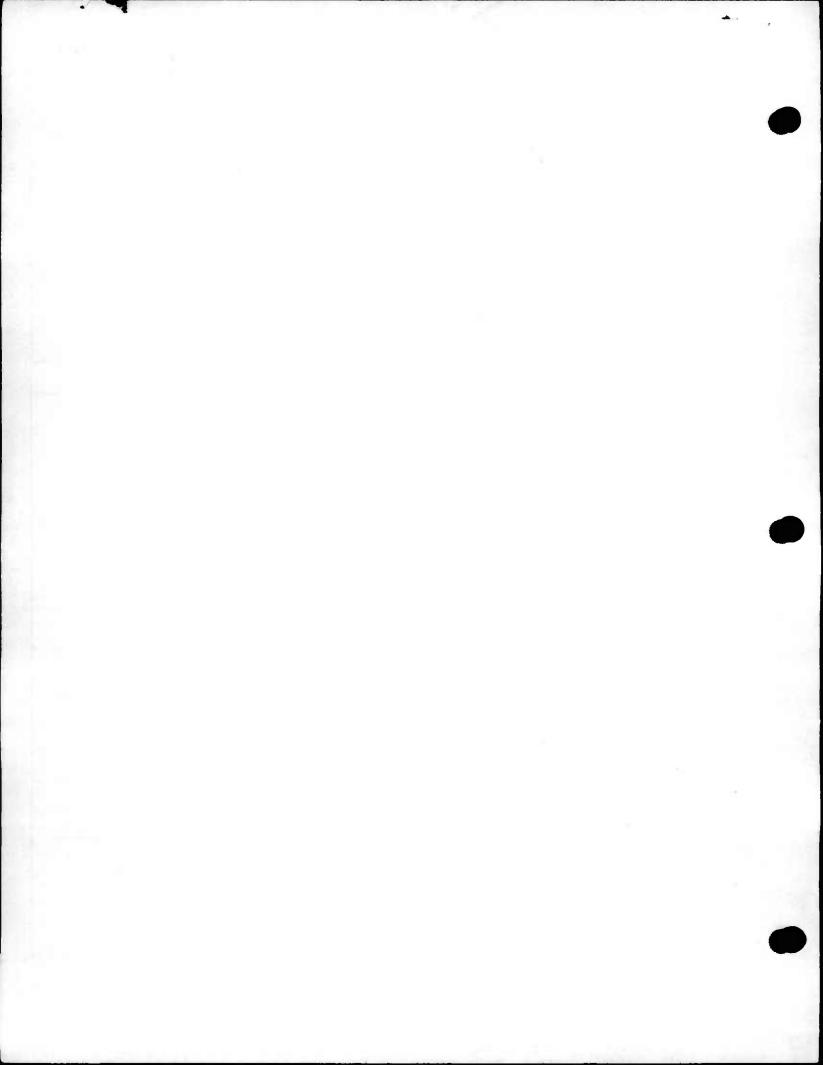
90 34066 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH** REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) (LAWRENCE TOWNSEND) 3. TIME OF DEATH YEAR cursent, au 1 36A-M 7. DATE OF BIRTH (Month, Day, Year) 6 - 18 - 10 4. SOCIAL SECURITY NUMBER 5. SEX, 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign Country) DAYS 1 2 M F 216-16-3982 N.C. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH BALTIMORE, MD. DIRECTOR LIBERTY MED. CENTER RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? BALTIMORE, CITY MD 1) YES 2 | NO FUNERAL 10s. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21216 4106 RIDGEWOOD AVE. USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yee, specify Cuban, Mexican, Puerto Ri FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify: BLACK 8 3 Vidowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY LET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4 t.h UPHOLSTERING 18. MOTHER'S NAME (First, Middle, Malden Surname)
MINNIE DAVIS 17. FATHER'S NAME (First, Middle, Last) LAWRENCE TOWNSEND BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Fural Route Number, City or Town, State, Zip Code) 2 SANTA FE DR.-FAYETTEVILLE, N.C. 28303 SONIA YOUNG 20b. PLACE OF DISPOSITION (Name of cornetery, crematory or 20e. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☐ Cremetton 3 ☐ Removal from State 20c. LOCATION — City or Town, State GREENMOUNT CEMETERY BALTIMORE, MD. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEI 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each lina. Interval Between Onset and Death IMMEDIATE CAUSE (Final disease or condition_ espirator resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Pheumona CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): Ob. Alelectasu if eny, leading to immediate cause. Enter UNDERLYING 19 hA CAUSE (Disease or injury DUE TO OR AS A CONSEQUENCE OF: that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL MAIL ARLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural
Accident 5 Pending Investigation 1 YES 2 NO 84 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 8 Could not be 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) **BE** -90 D33588 1/2-2 2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) unenc

32. REGISTRAR'S SIGNATURE e Davidson-Randalle

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 nours after death. Page 6 may be retained by the retained by the type of the property filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hydiene prior to burial, cremation, or removal.

IMPRITAIN: If item 28 is marked, or litem 23 shows any Inlust, or offler traumatic event, the medical examinar must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | | | OF HEALT | | | YGIENE IEG. NO. | 90 | 34067 | |
|---------------|---|--|--|--------------|----------------------|------------|------------------|-----------------------------------|--|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Mar Shall | C 4 | hos | na | 3 | | 2. DATE OF MONTH | DAY | 90 | 3. TIME OF DEATH | |
| | 216-50-4340, | SEX 6. AGE (10 for | VRS. | IF UNDER | DAYS HOURS | ER 24 HRS. | 7. DATE OF I | | 8. BIRTI Count | HPLACE (State or Foreign | |
| ron | 9e. FACILITY NAME (If not institution, give street | HOSP. | | 9b. CITY, | TOWN OR LOCA | TION OF DE | EATH | 9c. C | DUNTY OF E | DEATH | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. C/1 |) | R LOCATION | RE | | 10d. INS | | | |
| FUNERAL | 10c. STREET AND NUMBER 33/5/6424MC | WT ST | | | 101. ZIP CO | | 9 | 10g. (| TIZEN OF | WHAT COUNTRY? | |
| BY | | . WAS DECEDENT EVER IN U.S FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | 2 And If yes, specify Cuban, Mexican, Puerto Ric | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) JALEMP 4.0 4.50 | | | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Leat) 18. MOTHER'S NAME (First, Middle, Melden Surname) LEOLA KELLY HARMO | | | | | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) OHN KELLY 20a. METHOD OF DISPOSITION | | 331 | ELL | AMOU | TST | 0 | City or Town, State, | 213 | 124 | |
| | 1 Donation 5 Other (Specify) | from State | ner place) | IMU | | 15M7 | | BAL | - City or To | 1D | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | SEE) (L.L. | | Jo | VAME AND ADDI | Le K | رعبا | Aug | 21 | 211 | |
| | 23. PART I. Enter the diseases, or com- shock, or heart fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | plications that caused the tonly one cause on each | Sep | sis | the mode of o | lying, suc | | or respiratory | errest, | Approximate interval Between Onset and Deat | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | |
| SERTIF | that initiated events resulting in death) LAST | 502 10 (011 10 10 00 | MISEOUENCE C | | | | | | | | |
| MEDICAL | PART ii. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b, WERE A | | | | | | | | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | OTHER | 26. PLACE OF | DEATH (Ch | neck only one) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 1 ☑ Netural 5 ☐ Pending | Inpetient 2 ER/Outpetie 28a, DATE OF INJURY (Month, Dey, Year) | 26b. TII | 4 🗆 Nun | 28c. INJURY AT WORK? | | | Decity) | OCCURED | | |
| TED BY | 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, | street, fact | | | | ON (Street and Nun bwn, State) | iber or Rural | Route Number, | |
| COMPLETED | 2001 | N: To the best of my knowledg | | | | | | | | (a) and manner as stated. | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER Wissam Chat (30. NAME AND ADDRESS OF PERSON WHO C | ila, M.D. | 7 | D. C. | | N/A | | • | 12, | 0 (Month, Day, Year) | |
| - | 9 | CHAT | ILA | C C | CMa; | ss/ | nd Ge | neral. | Hosp. | ital | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATU | IRE | | | | | | | | |



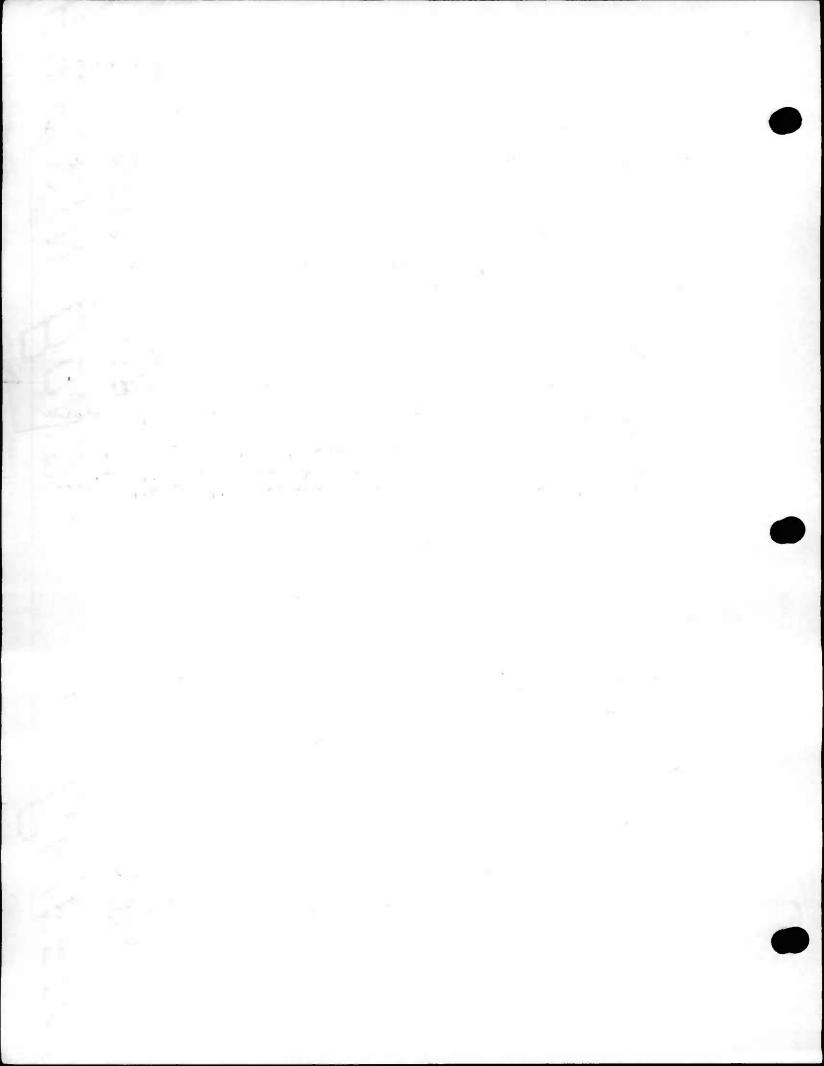
DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

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| 6, | within |
| 1314 | executed |
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TALL OR ATTENDING DHYSICIAN. The law requires that the death certificate be executed within a |
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| 1 | 1. DECEDENT'S NAME (First, Middle, Lest) | | 2. DATE OF OEATH MONTH DAY | | | | YEAR | 3. TIME OF DEATH 3:10 A | | | | |
|---------------|--|---------------------------|-------------------------------|----------------|--|-------------------------------|---------------|------------------------------------|--------------|-------------|---------------------------------------|--|
| 1 | ANASTASIA FORTUNATA 4. SOCIAL SECURITY NUMBER 6. SEX 6. AGE (In yrs. In | | | | | | | /2 7 90 7. DATE OF BIRTH 8. BIR | | | | |
| | | 1 M 2 F | 6. AGE (In yrs | YRS. | MONTHS DAYS | | 12.60 | nth, Day, Year) | 94 | Count | IPLACE (State or Foreign | |
| 4 | 214-25-2506 | | / | ins. | | | 4 | 19 | 89 | | ARYLAND | |
| NO BO | 98. FACILITY NAME (IT NOT INSTITUTION, giveystreet and number) 96. COUNTY OF DEATH UNIVERSALY OF MARY CAND MEDICAL SYSTEMS BALTINGRE BALTINGRE | | | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | | | | ry, TOWN OR LOC | | | | | | 10d, INSIDE CITY | |
| Ē | 1 | | | | | | | | LIMITS? | | | |
| | MARYLAND BAT | 101 | HET IMOR | IOT. ZIP CODE | _ | | 40a CIT | TIZEN OF | YES 2 NO | | | |
| FUNERAL | 2427 MAOIS | d Flo | | 2121 | | | | L. S. | WHAT COUNTRY | | | |
| ¥ | 11. MARITAL STATUS | 12. WAS DECEDER | | | | ECENDENT OF HIS | | IN? (Specify Ver | _ | _ | E — American Indian, | |
| | 1 Never Married 2 Married FORCES? 1 YES, GIVE WAR O | | | NO | If yes, | specify Cuban, Me S 2 NO S | exican, Puane | | | Blac | k, White, atc. | |
| B | 3 Widowed 4 Divorced | 17 123, 0172 | ON DAILS | | 1 | is 2 no s | расну. | | | apur | "White | |
| COMPLETED | 15. DECEOENT'S ED (Specify only highest grad | | 16a | . DECEDENT'S | S USUAL OCCUPAT | TION | 10 | b. KIND OF BU | SINESS/IN | DUSTRY | | |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | life. Do NOT u | ise retired.) | nost or working | | | | | | |
| 린 | Ø | | | | N/A | | | | N | /A | | |
| Š. | 17. FATHER'S NAME (First, Middle, Last) | | S | | | 18. MOTHER'S | S NAME (First | , Middle, Maiden | Surname) | | | |
| BE | EOWARD CH | ARLES 1 | BAVI. | 5 | | LISA | FRA | NCES | CA | 1e | 51 | |
| | 19e. INFORMANT'S NAME (Type/Print) | | | 19b. MAILING | G ADDRESS (Stree | | | | | ip Code) | | |
| 2 | Lisa F. Tesi | | | 2427 | Madis | on Ave | enue | Balt: | imor | e, I | MD 21217 | |
| ĺ | 20a. METHOD OF DISPOSITION 1 Burlal 2 Cramation 3 Re | and from State | 20b. PL/ | ACE OF DISPO | SITION (Name of o | cemetery, crematory | or or | - v | CATION - | | | |
| - 1 | 4 Donation 5 Other (Specify) | moval from State | _ | | o Crem | atory. | Inc | . 1 | Balt | imo | re, MD | |
| | 21. SIGNATURE OF FUNERAL SERVICES | CENSEE | 1/1/ | | 22. NAME | AND ADDRESS O | F FACILITY | | | | | |
| | Jeog - | NG - NI - 2-2- | 16 | | | ation | | | | | | |
| | George E. | | | 4 0 0 | | | | | | | MD 21228 | |
| | 23. PART i. Enter the disesses, or shock, or heart failure | | | | not enter the n | node of dying, | such as ca | rdiac or reap | Iratory a | rrest, | Approximata Interval Between | |
| | IMMEDIATE CAUSE (Final | 0 | | 1 | | | | | | | Onset and Dea | |
| | disease or condition resulting in death) | · CARE | O (OR AS A COI | ARRE | 21 | | | | | | 10 | |
| | | | | | | 7 | | | | | | |
| 8 | Sequentially list conditions, M. Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| F | if any, leading to immediate cause. Enter UNDERLYING | 0-1 | On As A CO | A | mj. | 16. | | | | | | |
| 은 | CAUSE (Disease or Injury | c. OM | O (OR AS A COI | NSEQUENCE O | 150F | HIV | | | | | | |
| Ē | that initiated events resulting in death) LAST | 411 | | | 700/ | | 15 | | | | į | |
| CERTIFICATION | | d. //// | 101 | -60 | 100 | ALL | 0 | | | | - | |
| - 11 | PART II. Other significant condition | ons contributing to | o death but n | ot resulting | In the underly | ing cause give | n In Part I. | 24a. WAS AN PERFO | | 24 | . WERE AUTOPSY FINDING | |
| MEDICAL | HX PAVELIMOCYS | TIS CHRAN | 11 PME | MONI | 4. Des | EMINA | Da | 1 TES | | | COMPLETION OF CAUSE OF DEATH? | |
| E I | CANDIDA DESSE | MANATEL | CYTO. | APGIO | VIRUSE | env+ | RNU | | 7 | | 1 TES 2 NO | |
| _ | RETINITIS and TO | , ,, | | | | | | AMTHA | 11/17 | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | C / C C / r | | PLACE OF DEATH | | | 1017 | | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inputient 2 | ☐ ER/Outpetlet | nt 3 KDOA | OTHER: | ome 5 Realde | nce 6 🗆 Ot | her (Specify) | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE O | FINJURY | 28b. TII | ME OF 28c, I | NJURY AT | | EŞCRIBE HOW | INJURY O | CCUREO | · · · · · · · · · · · · · · · · · · · | |
| | 1 Natural 5 Pending | | Day, Year) | | and the same of th | WORK? YES 2 NO | , | | | | | |
| BY | 2 Accident investigation 3 Suicide 6 Could not b | 26e. PLACE | OF INJURY - | At home, farm, | street, factory, of | fice | | CATION (Street | | er or Rural | Route Number, | |
| Ē | 4 Homicide determined | Sunoning | , etc. (Specify) | | | | , a | ty or Town, State |) | | | |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHY | SICIAN: To the heat | d mu knaudada | a death easin | and at the time of | | 1 4 1 1 | | | | | |
| ₽ I | onel | | | | | | | | | | e) end manner as stated. | |
| | | - | | | | E-20070VIII | | | - | | | |
| BE | 296. SIGNATURE AND TITLE OF CENTUR | 1/ | 1 | | | D 20 | 2091 | , | 29d. DA | TE SIGNE | D (Month, Day, Year) | |
| 2 | rear | 1 Cm | W | > | | 1007 | 1011 | | _/ | 2- | +-70 | |
| | 30. NAME AND ADDRESS OF PERSON V | HO COMPLETED CA | USE OF DEATH | (ITEM 27) (Typ | e, Print) | 114.m 1 | lmine | 0 | 2 1 | 40 | 7-90 MUREMO | |
| | 22 S. GR | EENE | OF. | UNIO. | OF MIKE | CHUO MI | EUIUN | OFFIC | 7 | AUL | viole je | |
| | 31. DATE FILED (Mann Day, Year) | | AAAAAA | RE L.O. | Navida- | Randall | | | | | | |
| - 1 | | DEC 11 | 1991 | guna | Industrial and | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



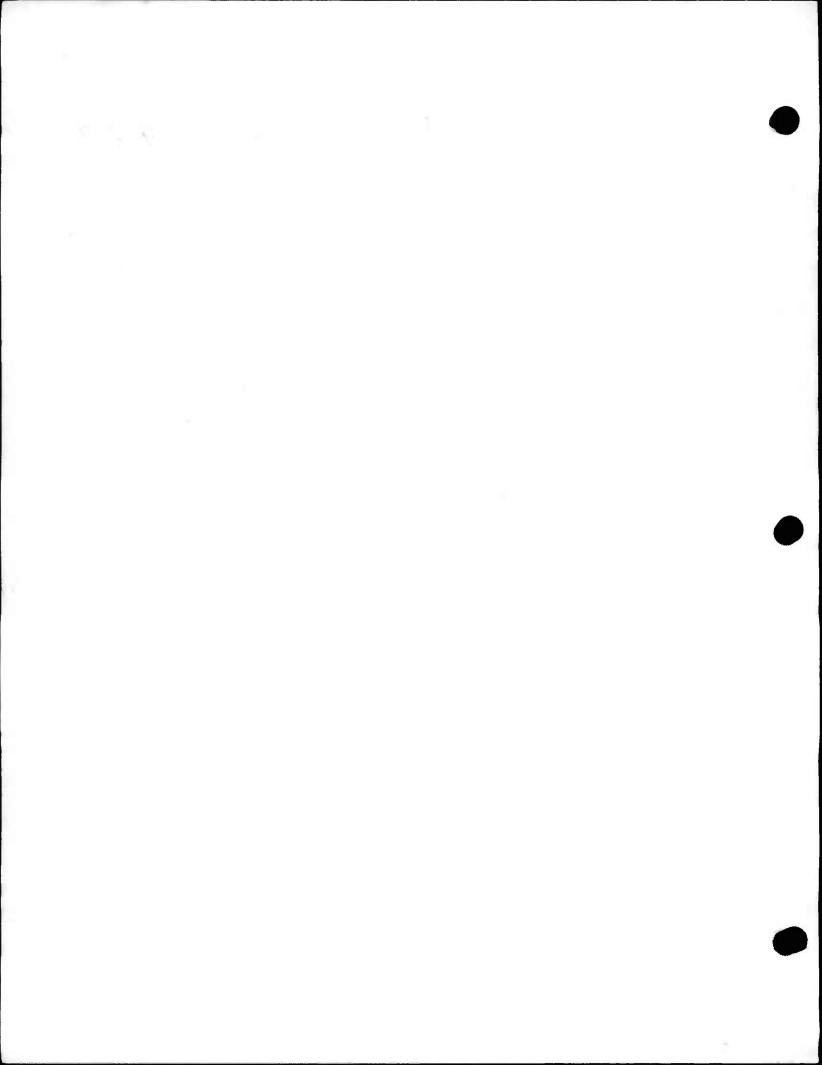
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | OIRIE OF MAILIE | | ICATE OF | DEATH | REG. | NO. | | | | |
|---------------|---|--|---|--|---|-----------------------------------|---|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Towse | CN CN | | | 2. DATE OF DEAT | BO (| YEAR 3. T | ME OF DEATH | | |
| | | | n yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS, HOURS MIN. | 7. DATE OF BIRTH | 1930 | Country) M | E (State or Foreign ICHIGAN | | |
| TOR | Baltimore County General Hosp. Randalstown MD Baltimor | | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY MD But | imore | | Y, TOWN OR LOCAT BALL'L'IMOR | | | | | . INSIDE CITY LIMITS? YES 2 NO | | |
| FUNERAL | 10a. STREFT AND NUMBER 12 FENCE POST CT. | | | 10f | ZIP CODE | 1208 | COUNTRY? | | | | |
| B | 11. MARITAL STATUS 1 | Never Married 2 Married FORCES? 1 YES 2.X | | | ENDENT OF HISPAN scify Cuban, Maxica 2 NO Specify | n, Puarto Rican, at | ORIGIN? (Specify Yea or No— Black, White Specify: | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | ATION ompleted) College (1-4 or 5+) | (Give kind of life. Do NOT u | USUAL OCCUPATION Work done during mose retired.) | ON st of working | | F BUSINESS/INDU | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) EDWARD IM | MERMAN | INIT | ROS _I O. | | ME (First, Middle, M MIRIAM L | | G | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) MR. JAY M. TOWSEN | D | | ADDRESS (Street a | OOD DR. | Poute Number, City of BALTIMO | | ^{Code)} 21208 | | | |
| | 20e. METHOD OF DISPOSITION 1 by Burlel 2 Crementon 3 Memoria 4 Donation 5 Quiner (Specify) | PLACE OF DISPO | E OF DISPOSITION (Name of cemetery, cremetory or AR SINAI OWINGS MILLS, | | | | | | | | |
| | 21. SIGNATURE OF MINERAL PERVICE LICE | HAMAN | | 22. NAME AT SOL 6010 | LEVINSO REISTER | CILITY N & BROS STOWN RE | | 'IMORE | ,MD 21215 | | |
| CERTIFICATION | 23. PART I. Enter the diseases, or cr ahock, or heart failure. L immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | iat only one cause on a | filmilla Reast f | troi | h as cardiac or | raapiratory arre | eat, | Approximata interval Batween Onset and Death | | | |
| DICAL CE | 10, | parens | ut not resulting | in the underlyin | g cause given in | PI | AS AN AUTOPSY ERFORMED? | AVA | RE AUTOPSY FINDINGS ULABLE PRIOR TO MPLETION OF CAUSE DEATN? | | |
| ME | Rypothyroc Insulin | dependent c | Maleko | m ellit | The s | _ | | 1 [| YES 2 NO | | |
| SICIA | | HOSPITAL: 1 Inpatient 2 ER/Outp | nettone 2 DOS | OTHER: | LACE OF DEATH (Ch | | | | | | |
| BY PHYSICIAN: | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b, TIR | NE OF 28c. INJ | JURY AT DRK? YES 2 NO | | HOW INJURY OCC | URED | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY building, etc. (Spec | | street, factory, offic | 10 | 28f. LOCATION (S City or Town, | Street and Number State) | or Rural Route | Number, | | |
| COMPLETED | 0001 | RIAN: To the best of my known: R: On the basia of examination | | | | | | | d manner as stated. | | |
| BE | 296. SIGNATURE AND ATLE OF CERTIFIER | makky me | > | | 29c. LICENSE NUI D3828 | | | 2-09- | | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | ephy MD | | | | | | | | | |
| | DEC 11 1990 | 32 REGISTRAM'S SIGN | 1- Mandall | | | | | | | | |

an.
L'iransit permit. Pages 1, 2, 3 should

BALTIMORE, MARYLAND 212 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be fled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89



DHMH-16 Ray 1/89

the bring in most permit. Pages 1, 2, 3 should

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or an TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filled within 72 hours after death with the State Dept. of Health and Memal Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | OLITIII | ICATE OF DEATH | REG. NO. | | | |
|------------------------------------|--|--|--|---|---|--|--|
| | 1, DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF DEATH | | |
| Į | | TNUR | | 12 7 | 90 4 | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 6. BIRTHPLACE (State or Foreign Country) | | |
| 1 | 213-16-7999 10 M 22 | F YRS. | | 2712 | MARYLAND | | |
| - 17 | 9e. FACILITY NAME (If not institution, give street end number |) | 9b. CITY, TOWN OR LOCATION OF D | EATH 9c. | COUNTY OF DEATH | | |
| Ĕ. | 615 N. CALHOUN STEEL BALTIMORE | | | | | | |
| ĸ | RESIDENCE OF DECEDENT | | | | | | |
| ñ | 10e. STATE 10b. COUNTY | 10c. CIT | TY, TOWN OR LOCATION | | 10d. INSIDE CITY | | |
| DIRECTOR | MARULAND | B | ALLIMORE | | 1 YES 2 NO | | |
| | 10e. STREET AND NUMBER | | 10f. ZIP CODE | 109 | g. CITIZEN OF WHAT COUNTRY? | | |
| FUNERAL | 615 N. CALHUUN | STEEFT | 212 | 17 | | | |
| 3 | | EDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPA | | lo 14. RACE — American Indian, | | |
| | 1 Never Merried 2 Merried FORCES? | 1 YES 2 NO VE WAR OR DATES | If yes, specify Cuban, Mexic 1 TES 2 NO Speci | | Black, White, atc. | | |
| B | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify | | | | | | |
| ۵ | 15. DECEDENT'S EDUCATION | 16a. DECEDENT'S | S USUAL OCCUPATION | 16b. KIND OF BUSINES | | | |
| | (Specify only highest grade completed) | Ilfa. Do NOT u | work done during most of working use retired.) | | | | |
| ב ו | Elementery/Secondary (0-12) College (1-4 | Dom Dom | E541 E | | | | |
| COMPLETED | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | 16. MOTHER'S NA | AME (First, Middle, Maiden Surni | | | |
| BE | 0///// |) | 111010 | 1 CORNIS | | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAJLING | G ADDRESS (Street and Number or Rural | Route Number, City or Town, Sta | ete, Zip Code) | | |
| Ĕ | ESTE ILE BATNES | 1712 | 17th Street | 24 WASH | ingfin, O.C. | | |
| | 20e METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State | 20b. PLACE OF DISPO | SITION (Name of cemetery, crematory or | 20c. LOCATI | ON — City or Town, State | | |
| | 1 Buriel 2 Cremation 3 Removal from State | M) & 5 TEK | NSTAL Como | true CATON | USUILE MAYGUAL | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 0020.010 | 22. NAME AND ADDRESS OF F | ACILITY | 12 4 1 1 P 1 | | |
| | . 2 . // | | | | 38 N. 01 Lmd- | | |
| | John Hurr | 1 | LEroy HATT | ISTA. E | BALTIMOIE, MDZI | | |
| - 11 | 23. PART I. Enter the diseases, or complications | | not antar the mode of dying, su- | ch as cardiac or reapirato | ry arreat, Approximata | | |
| | shock, or heart failure. List only one cause on each line. | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | |
| | | 1.1 | | 0 | Onset and Death | | |
| | iMMEDIATE CAUSE (Final diagage or condition resulting in death) | ecut - | tanillar | 2 | Onset and Death | | |
| | diaaaaa or condition | E TO OM AS A CONSEQUENCE O | Laulyn | 2 | Onset and Death | | |
| N | diasasa or condition resulting in death) | E TO JOH AS A CONSEQUENCE OF | te sand | e e e e e e e e e e e e e e e e e e e | Onset and Death Night 54 you | | |
| LION | diaaaaa or condition resulting in death) a | E TO OH AS A CONSEQUENCE OF | to can | e e e e e e e e e e e e e e e e e e e | Onset and Death Onset and Death | | |
| CATION | diaaaaa or condition resulting in death) Sequantially list conditions, if any, leading to immadiata cause. Entar UNDERLYING | y besters | te can | e e e e e e e e e e e e e e e e e e e | Onset and Death Onset and Death | | |
| IFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or plury Co. | y besters | Ve can | Moderala | Dusels 54 Jan | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | E TO OR US A CONSEQUENCE | Ve can | e e e e e e e e e e e e e e e e e e e | Diselle 54 Jan | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | E TO OR US A CONSEQUENCE | Ve can | e e e e e e e e e e e e e e e e e e e | Onset and Death Diselse 54 you | | |
| | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | E TO OH AS A CONSEQUENCE OF | Ve sand | | Delle 57 jour | | |
| | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | E TO OH AS A CONSEQUENCE OF | Ve sand | PERFORMED | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | E TO OH AS A CONSEQUENCE OF | Ve sand | | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | E TO OH AS A CONSEQUENCE OF | Ve sand | PERFORMED | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| EDICAL | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing | E TO OH AS A CONSEQUENCE OF | Ve sand | PERFORMED | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| EDICAL | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing the cause of the | E TO OH AS A CONSEQUENCE OF | In the underlying cause given in | PERFORMED | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| EDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributions. | E TO OH AS A CONSEQUENCE OF | In the underlying cause given in | PERFORMED 1 YES 2 heck only one) | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| EDICAL | Sequentially list conditions, if any, leading to immadiata cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing in death (Cause Cause) and (Cause Cause | E TO ON AS A CONSEQUENCE OF TO (ON AS A CONSEQUE | 28. PLACE OF DEATH (COTHER: 4 Nursing Home 5 Residence | PERFORMED 1 YES 2 heck only one) | TOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing in the cause of the conditions contributing in the cause of the cause o | E TO ON AS A CONSEQUENCE OF TO (ON AS A CONSEQUE | 28. PLACE OF DEATH (COTHER: | PERFORMED VES 2 heck only one) 8 Other (Specify) | TOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing in the cause of the conditions contributing in the cause of the cause o | E TO OH AS A CONSEQUENCE OF TO (OH AS A CONSEQUE | 28. PLACE OF DEATH (CONTINUE AND | heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing the cause of the conditions contributing the cause of th | E TO ON AS A CONSEQUENCE OF TO (ON AS A CONSEQUE | 28. PLACE OF DEATH (CONTINUE AND | heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU | TOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? PART II. Other significant conditions contributing the conditions conditions contributing the conditions contributing the conditions contributing the conditions conditions contributing the conditions conditions conditions contributing the conditions | E TO OH AS A CONSEQUENCE OF TO OH OH AS A CONSEQUENCE OF TO OH | 28. PLACE OF DEATH (CONTINUE AND | heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU 28f. LOCATION (Street and is | TOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 VES 2 NO | | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing in the cause of the conditions contributing in the cause of the cause | E TO OR AS A CONSEQUENCE OF TO (OR AS A CONSEQUENCE OF INJURY — At home, farm, dding, etc. (Specify) | 28. PLACE OF DEATH (CONTINUE AND | heck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU- 28f. LOCATION (Street and Inc.) City or Town, State) | TOPSY D? NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, | | |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contribution of the con | E TO OR AS A CONSEQUENCE OF TO OR AS A CONSE | 28. PLACE OF DEATH (CONTHER: 4 Nursing Home 5 Residence ME OF WORK? 1 YES 2 NO street, factory, office | PERFORMED NES 2 Neck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU- 28f. LOCATION (Street and Inc. City or Town, State) | TOPSY D? NO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, | | |
| COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? PART II. Other significant conditions contributing in death) LAST 27. MANNER OF DEATH Natural 5 Pending Investigation 28e. PLI (Mo determined 28e. PLI (Mo determined 28e. PLI (Mo determined 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDIC | E TO OR AS A CONSEQUENCE OF TO OR AS A CONSE | 28. PLACE OF DEATH (COOK) 28. PLACE OF DEATH (COOK) 4 Nursing Home 5 Residence ME OF UURY WORK? 1 YES 2 NO atreet, factory, office | PERFORMED TES 2 Theck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU 28f. LOCATION (Street and Inc.) City or Town, State) to the cause(e) and menner e time, date and place, and du | TOPSY 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, ee stated. ue to the ceuse(e) end menner ee atated. | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contribution of the con | E TO OR AS A CONSEQUENCE OF TO OR AS A CONSE | 28. PLACE OF DEATH (CONTHER: 4 Nursing Home 5 Residence ME OF WORK? 1 YES 2 NO street, factory, office | PERFORMED TES 2 Theck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU 28f. LOCATION (Street and Inc.) City or Town, State) to the cause(e) and menner e time, date and place, and du | TOPSY 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, ee stated. | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing the cause of the conditions contributing in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? PART II. Other significant conditions contributing the conditions contributing cause of the cause of the conditions cause of the ca | E TO OH AS A CONSEQUENCE OF TO OH AS A CONSE | 28. PLACE OF DEATH (COOK) OTHER: 4 Nursing Home 5 Residence ME OF UJURY M 1 YES 2 NO street, factory, office Tred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, end dul | PERFORMED TES 2 Theck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU 28f. LOCATION (Street and Inc.) City or Town, State) to the cause(e) and menner e time, date and place, and du | TOPSY 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, ee stated. ue to the ceuse(e) end menner ee atated. | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? PART II. Other significant conditions contributing in death) LAST 27. MANNER OF DEATH Natural 5 Pending Investigation 28e. PLI (Mo determined 28e. PLI (Mo determined 28e. PLI (Mo determined 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the beel of the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDICAL EXAMINER: On the publication 28e. PLI (Check only one) 2 MEDIC | E TO OH AS A CONSEQUENCE OF TO OH AS A CONSE | 28. PLACE OF DEATH (COOK) OTHER: 4 Nursing Home 5 Residence ME OF UJURY M 1 YES 2 NO street, factory, office Tred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, and dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, in my opinion, death occurred at the time, date end place, end dulion, end dul | PERFORMED TES 2 Theck only one) 8 Other (Specify) 28d. DESCRIBE HOW INJU 28f. LOCATION (Street and Inc.) City or Town, State) to the cause(e) and menner e time, date and place, and du | TOPSY 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RY OCCURED Number or Rural Route Number, ee stated. ue to the ceuse(e) end menner ee atated. | | |
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FOR STATE REGISTRAR

1. DECEDENT'S NAME (First,

7. DATE OF BIRTH (Month, Day, Year) 03-08-28 IF UNDER 1 YEAR Pages 1, 2, 3 should 9c. COUNTY OF DIRECTOR Baltimore City RESIDENCE OF DECEDENT INSIDE CITY LIMITS? 10b. COUNTY 10c. CITY, TOWN OR LOCATION Maryland Baltimore City 1 X YES 2 NO permit. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 611 South Charles Street 21230 lay be retained by the hospital or attending physician. page 5 should be detached for use as the burial-transit 21230 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, aic. If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES 1 X Never Married 2 Married BY 3 Widowed 4 Divorced White ED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Ē Elamentary/Secondary (0-12) College (1-4 or 5+) COMPL Dependent 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Malden Surname) Albert Ħ Vierling Sr. Helen Μ. Koenia BE notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Mary H. Masek 818 Suburbian Rd. Reisterstown, Md. 21136 after death. Page 6 may be be 20a. METHOD OF DISPOSITION
1 [X] Burlel 2 Cremation 3 Ren
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State must Baltimore Moreland Mem. Maryland 12/10/90 Milton examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Knight Jr 21214 funeral Leonard J. Ruck, Inc. 5305 Harford Rd. filled in by the fion, or removal. medicai 23. PART i. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory arrest, shock, or heart feliure. List only one cause on each line. interval Between б Onset and Death IMMEDIATE CAUSE (Final signed by the attending physician and completely fille Health and Mental Hygiene prior to burial, cremation, the disease or condition resulting in daeth) DUE TO (OR AS A CONSEQUENCE OF): event, eufe pyclonephyta traumatic CERTIFICATION Sequentially list conditions, DUE TO (Q) AS CONSEQUENCE if any, leading to immediate cause. Enter UNDERLYING **CAUSE** (Disease or injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST 6 PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MEDICAL 24a. WAS AN AUTOPSY dation secondary to consente AVAILABLE PRIOR TO any COMPLETION OF CAUSE 1 - YES 2 1 1 TES 2 THO s certificate has been the state Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item HOSBITAL: **EXAMINER?** OTHER: 1 YES 2 NO stient 2 - ER/Outpetient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 6 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 26b. TIME OF INJURY 28d. DEŞCRIBE HOW INJURY OCCURED with t marked, 1 Natural 5 Pending 1 YES 2 NO DIRECTOR: After the hours after death vitem 28 is mark BY 2 Accident 26a, PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated. FUNERAL within 72 h IMPORTANT: IL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and m 29b. SIGNATUR 29d. DATE SIGNSD (Mogth, Day, Year) 29c. LICENSE NUMBER TO THE P BE H 2 601 S. Chelos St. Boltmore. 1alos

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

Vierling

Albert

34071

3. TIME OF DEATH

REG NO

2. DATE OF DEATH

permit. Pages 1, 2, 3 should

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-tran | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or remoral. | IMPORTANT. If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|--|
| TO THE HOSPITAL OR ATTEN | TO THE FUNERAL DIRECTOR: | be filed within 72 hours after | IMPORTANT: If Item 28 Is |

90 34072 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATN Tame el 8:40 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year 8 - 27 IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign DAYS HOURS 1 4 2 F MONTHS MIN. NORTH CARO 246181547 YRS. 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR RESIDENCE OF DECEDENT TIMORE 10a. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? 10c, CITY, TOWN OR LOCATION Min BALTIMURE 1 TES 2 NO FUNERAL 10e. STREET AND NUMBER 18g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 21217 3501 HOLMES U.S.A 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 1 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify if yes, specify Cuban, Mexican, Puerto Rican, etc.) If yes, specify Cuban 1 Never Married 2 Married IF YES, GIVE WAR OR DATES BY 1 YES 2 JANO Specify: 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INOUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) LUINDIE VOHY BE 19a, INFORMANT'S NAME (Type/Print) 2 MARY 3501 WINDLE Mo 20a. METHOD OF DISPOSITION
1 Deurial 2 Cremation
4 Donation 5 Other (Soc 20c. LOCATION 20b. PLACE OF DISPOSITION (Nat n 3 🗆 on 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY 2222 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Betw **IMMEDIATE CAUSE (Finel** Onset and Death disesse or condition resulting in death) DUE TO (OR AS A CO MEDICAL CERTIFICATION 1.911 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initieted events resulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 | YES 2 10 NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA Nome 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE NOW INJURY OCCURED 1 Natural м 1 YES 2 NO Β¥ 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 8 Could not be detarmined COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno 2 MEDICAL EXAMINER: On ti on, death occured at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 378

LETED CAUSE OF DEATN (ITEM 27) (Type, Print)

Mande 19

. REGISTRAR'S SIGNATURE

1990



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25-mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

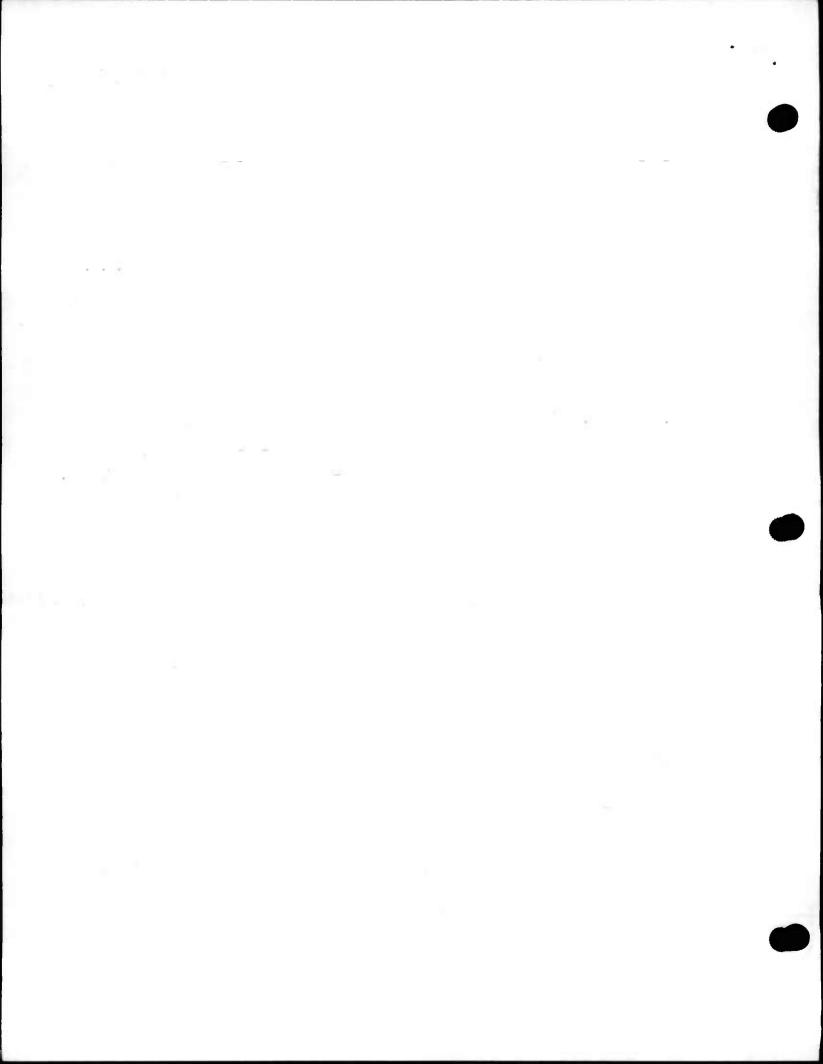
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

34073 90

DHMH-16 Rev 1/89

| FOR STATE REGISTRAR | | STATE OF N | | / DEPAR | | | ALTH AND I | MENTA | REG. NO. | 9 | U | 34073 |
|---|---|---------------------------|-----------------------------|-------------------------------|---------------|------------------------|--------------------------------|------------------|---------------------------|-----------------|-------------------|--|
| 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | 2. DATE | OF DEATH | | YEAR | 3. TIME OF DEATH |
| LONA | A ELLEN | V | WILLS | | | | | 12 | | | 90 | 2:18 P M |
| 4. SOCIAL SECURITY NUMB | | SEX | 6. AGE (In yrs. I | | IF UNDER 1 | - | F UNDER 24 HRS. | 7. DATE (Mont | OF BIRTH h, Day, Year) | 8 | Country) | LACE (State or Foreign |
| 216-34-8954 | | □ M 2 💢 F | 54 | YRS. | | | | | n, Day, Year) -4-1936 | | | YLAND |
| 9e. FACILITY NAME (If not in: | | | | | | | LOCATION OF DI | EATH | | 9c. COUNT | | |
| THE JOHNS | HOPKINS | HOSPI | TAL | | BALT | TIMOF | RE | | | BALT1 | MOR | E CITY |
| 10e. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN OF | | | | | | | 10d. INSIDE CITY LIMITS? |
| MARYLAND 100. STREET AND NUMBER | BAI | LTIMORE | | | | _ | DUNDALK | | | | | 1 🗆 YES 💥 NO |
| 1742 BURNHA | N DAAD | | | | | 107. Z | 1P CODE 212: | n n | | 10g. CITIZE | | AT COUNTRY? |
| 11. MARITAL STATUS | | . WAS DECEDEN | T EVER IN U.S. A | RMED | 13. W | AS DECEN | DENT OF HISPAI | | N? (Specify Yea | or No— 1 | A. BACE | S.A. - American Indian, |
| 1 Never Merried 2 | Merried | FORCES? 1 | YES 2 | NO | | | ty Cuban, Mexica NO Specifi | | | | Black, Specify | White, atc. |
| 3 Widowed 4 Divo | | | | | | | | | | | | WHITE |
| (Specify only | EDENT'S EDUCATION PROPERTY FOR A COMPANY OF THE PROPERTY OF T | pleted) | | Give kind of ville. Do NOT us | vork done du | CUPATION uring most | of working | 181 | . KIND OF BUS | INESS/INDU | STRY | |
| Elementary/Secondary (0 12TH GRADE | | ollege (1-4 or 5 - | •) " | | MAKE | ED. | | | | HOME | | |
| 17. FATHER'S NAME (First, M. | | V/ F\ | | HOME | MAIN | | IS. MOTHER'S NA | ME (First. | Middle, Maiden | | | |
| MELVIN HARR | ISON | | | | | | IDA I | MAE | JULIAN | | | |
| 19e. INFORMANT'S NAME (7) | | | | 19b. MAILING | ADDRESS | (Street and | Number or Rural | | | n, State, Zip C | Code) | |
| REV. GEORGE | A. WILL | S | | 174 | 2 BUF | RNHAN | 1 ROAD | BAI | LTIMORE | , MAR | RYLAI | VD 21222 |
| 20a, METHOD OF DISPOSITI | iON on 3 \square Removal | from State | 206. PLAC other DULAN | niaca) | | | tery, crematory or | | | CATION — C | | |
| 4 Donation 5 Other | | er O | UULAN | IEY VA | | _ | ADDRESS OF FA | | -90 TIN | <u>iontui</u> | 1. M | ARYLAND |
| S. S. S. | 707 | | | | 100 | JDA-1 | RUCK FUI | NERAI | | | | LK, INC. |
| 1 | XX | 1 | | | | | SE AVE | | | _ | | 21222 |
| 23. PART I. Enter the di shock, or h | iseeses, or com eart feilure. List | | | | not enter t | the mode | of dying, suc | ch ee cer | diec or reepi | ratory erre | et, | Approximete interval Between |
| iMMEDIATE CAUSE (Fir | nei | | | 1 | | | | | | | | Onset and Death |
| resulting in deeth) | → a | | (OR AS A CONS | | n. | | | | | | | IWK |
| | _ | | tropeu | | r): | | | | | | | 3-4 MO |
| Sequentially list condition if any, leading to imme | | | (OR AS A CONS | | F): | | | | | | | |
| cause. Enter UNDERLY | ING | AL | - L | | | | | | | | | ~2 Yrs |
| that initiated events resulting in death) LAS | | DUE TO | (OR AS A CONS | SEOUENCE O | F): | | | | | | | |
| resulting in death) LAS | d | | | | | | | | | | | |
| PART il. Other significe | ent conditions c | ontributing to | desth but no | t resulting | in the unc | derlying | cause given in | Part i. | 24s. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| | | | | | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| <u> </u> | | | | | | | | | / | | | 1 TYES 2 NO |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED T EXAMINER? | | OSPITAL: | | | OTHER | | CE OF DEATH (C | heck only o | nne) | | | |
| 1 NO | 1 | | ER/Oulpatient | _ | 4 🗆 Nurs | Ing Home | 5 Residence | | | | | |
| 27. MANNER OF DEATH | Pending | 28e. DATE Of (Month, L | | 28b. TIR | JURY M | 28c. INJUI WOR | RY AT K? S 2 NO | 28d. DE | SCRIBE HOW I | NJURY OCC | URED | |
| 2 Catalan | Investigation | 28e. PLACE (| OF INJURY — At | home, farm, | street, facto | | 3 2 10 | 281. LO | CATION (Street : | and Number | or Rural R | oute Number. |
| | Could not be determined | | etc. (Specify) | , , | | ,, | | City | or Town, State) | | | , |
| 290. CERTIFIER 1 CERT | TIFYING PHYSICIA | N: To the best o | my knowledge. | death occur | ed at the ti | me, date = | nd place, and du | e to the co | puse(s) and ma | ner en state | d. | |
| TOTACK OTHY | | _ | | | | | | | | | | end menner as atated. |
| 296. SIGNATURE AND THE | OF CERTIFIER | 0 | | | | Т | 29c. LICENSE NU | MBER | | 29d. DATE | SIGNED | (Month, Day, Year) |
| α | , A | im | | MA | | | | | | 1 12 | 1/6 | 190 |
| 30. NAME AND ADDRESS O | F PERSON WHO C | | 0.6 | | | | A | | | - | / | |
| DAVID | IM, | John | | PKIN | S H | ospi | toll | | | | | |
| 31, DATE FILED (Month, Day, | Year) | 32. REGISTR | AR'S SIGNATUR | E | | | | | | | | |





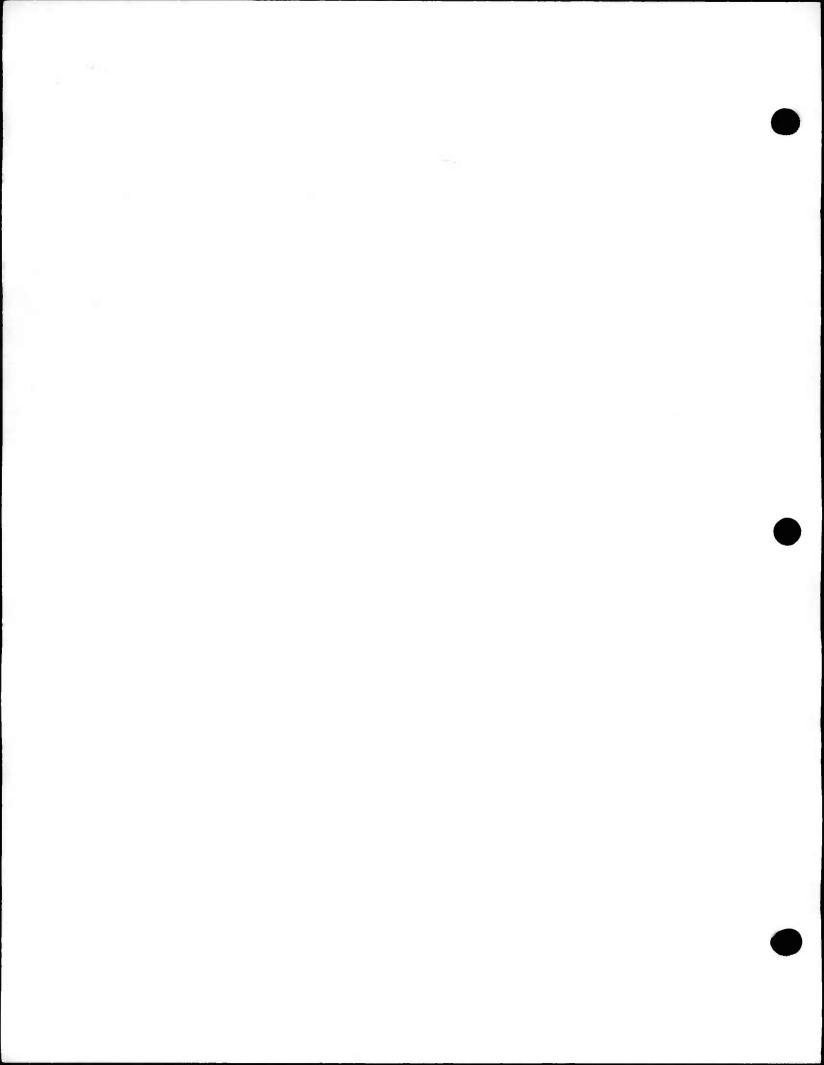
| - h | REGISTRAR 1. OECEOENT'S NAME (First, Middle, La: | (t) | | , | | DEATH | 2. DATE OF | | | 3. | 4014 TIME OF DEATH |
|------------------------------------|--|--|---|--------------------------------------|---|---|--|--|--|---|--|
| | Clarence Wilso | | | WilA | teres | n | MONTH | mber | 4 199 | YEAR | 2:05 9 |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. | last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | / 1 | B. BIRTHPL Country) | ACE (State or Foreign |
| | 221-10-693 | 1 🔀 M 2 🗆 F | 76 | YRS. | MONTHS DAYS | HOURS MIN. | 11/2 | 2/191 | 4 (| | oro, Dela |
| _ | 9e. FACILITY NAME (If not institution, give | | | | | OR LOCATION OF | | | 9c. COUNT | TY OF DEA | TH |
| 0 | PENINSULA GEN | ERAL HOSPITA | AL | | SALI | SBURY, MI |) | | WIC | OMICO |) |
| DIRECTOR | 10e. STATE 10b. COU | | | | TOWN OR LOC | | 70.100 | | | - 10 | Od. INSIDE CITY LIMITS? |
| . 11 | Delaware Suss | ex. | | Se | | le, Delav | vare | | 40 - 017171 | | YES 2 NO |
| RAI | 31 North Main | Stroot | | | | 19975 | | | USA | EN OF Wh | AT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEOENT EV | | | | ECENDENT OF HISP | | | | 14. RACE - | - American Indian, |
| BY F | 1 Never Merried 2 Married 3 Wildowed 4 Divorced | FORCES? 1 I | | [_NO | | specify Cuban, Mexic ES 2X NO Spec | | en, etc.) | | | white, etc. white |
| | 15, DECEDENT'S E | DUCATION | 160 | OECEDENT'S L | ISTIAL OCCUBA | TION | 16h h | IND OF BUI | SINESS/INDU | ISTRV | |
| ETE | (Specify only highest gr | | | (Give kind of we life. Do NOT use | ork done during i | most of working | 100. 7 | CINCO OF BOX | JIIIL JOYNOO | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
| 교 | 6 | conega (1-4 or 5 +) | C | onstruc | tion w | orker | C | onstr | uctio | n | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S | | ddie, Maiden | Sumeme) | | |
| BE (| William James Wi | 1kerson_ | | 401 1444 144 | 1000555 | Alice | | | - Dank 70 | 0-4-1 | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Ethel M. Wilkers | con | | | | t., Selby | | | | | 975 |
| | 20s. METHOD OF DISPOSITION | | 20b. PL/ | CE OF DISPOSI | TION (Name of | cemetery, crematory o | | | CATION - C | | |
| | Mariel 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) _ | emoval from State | Red | Men's | Cemete | ry | | Se1 | by vi l | le, I | Delaware |
| | 21. SIGNATURE OF FUNERAL BERNICE | LICENSEE | 1 | | | on Funer | | 0 Tn | C | | |
| | Techan - | T. Wat | en | | | sboro. De | | - | c. 966 | | |
| NO | immediate cause (Finel disease or condition resulting in death) Sequentially liet conditione, | b | AS A COI | NSEQUENCE OF |): | | | | | | Onset and De |
| CERTIFICATION | if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | c | | NSEQUENCE OF | , | | | | | | |
| ERT | | | | | | | 1,000 | 24a WAS AN | AUTOPSY | | WERE AUTOPSY FINDIN |
| MEDICAL | PART II. Other eignificent condi | | | | n the underly | ring ceuse given | | PERFO | | · (| COMPLETION DF CAUS OF DEATH? 1 YES 2 NO |
| MEDICAL | emphyse 25. WAS CASE REFERRED TO MEDICA | na (end | | | | ring ceuse given | | PERFO | | · (| OF DEATH? |
| SICIAN: MEDICAL | emphyse. | na (end | sta | 9-2 | 26. OTHER: | | Check only one | PERFOI | | · (| OF DEATH? |
| SICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: | S to | 9 2 nt 3 □ DOA | OTHER: 4 Nursing H E OF 28c. | PLACE OF OEATH (| Check only one | PERFOI YES (Specify) | | | OF DEATH? |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Pinpatlent 2 E 28s. OATE OF IN. (Month, Day, | S to | nt 3 DOA | 26. OTHER: 4 Nursing H E OF URY M 1 [| PLACE OF OEATH (lome 5 | Check only one e 6 Other 28d. OE\$4 | PERFOI YES: (Specify) CRIBE HOW | NO NO | CUREO | OF DEATH? |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Pinpatient 2 = E 28s. OATE OF IN. (Month, Dey. 28s. PLACE OF in. building, etc. | S fa | nt 3 DOA | 26. OTHER: 4 Nursing H E OF URY M 1 [| PLACE OF OEATH (lome 5 | Check only one e 6 Other 28d. OESC | PERFOI YES: (Specify) CRIBE HOW | NO N | CUREO | OF DEATH? |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 8 Could not datarmine 29e. CERTIFIER 1 CERTIFVING P. | HOSPITAL: 1 Pinpatient 2 = E 28s. OATE OF IN. (Month, Dey. 28s. PLACE OF in. building, etc. | J (a. R/Outpatien JURY Year) NJURY — (Specify) | nt 3 DOA 28b. TIMI | 25. OTHER: 4 Nursing H E OF 28c. URY M 1 [| PLACE OF OEATH (iome 5 | Check only one 6 Other 28d. OESt 291. LOCA City o | PERFOI 1 YES : (Specify) CRIBE HOW TION (Street | INJURY OCC | CUREO or Flural Ro | OF DEATH? |
| ED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 8 Could not datarmine 29e. CERTIFIER (Check only | HOSPITAL: 1 Prinpatient 2 E 28s. OATE OF IN. (Month, Day, be be d | J (a. R/Outpatter JURY Year) NJURY — / (Specify) | nt 3 DOA 28b. TIMI | OTHER: OTHER: 4 Nursing H E OF 28c. URY M 1 [street, factory, o | PLACE OF OEATH (lome 5 | Check only one 6 Other 28d. OESt 291. LOCA City o | PERFOI 1 YES : (Specify) (Specify) TION (Street r Yown, State | INJURY OCC | or Flural Ro | OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 8 Could not datarmine 29e. CERTIFIER (Check only | HOSPITAL: 1 Prinpatient 2 E 28a. OATE OF IN. (Month, Dey. 28e. PLACE OF III building, etc. HYSICIAN: To the beet of exam | J (a. R/Outpatter JURY Year) NJURY — / (Specify) | nt 3 DOA 28b. TIMI | OTHER: OTHER: 4 Nursing H E OF 28c. URY M 1 [street, factory, o | PLACE OF OEATH (iome 5 Residence inJURY AT WORK? YES 2 NO fflice late end place, end co | Check only one 6 Other 28d. OESt 291. LOCA City o | PERFOI 1 YES : (Specify) (Specify) TION (Street r Yown, State | and Number | CUREO or Flural Flo ed. as couse(e) | OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 YES 2 NO 27. MANINER OF DEATH 1 Netural 5 Pending Investigati 3 Suicide 8 Could not datarmine 290. CERTIFIER (Check only one) 2 MEDICAL EXAMINER OF CERTIFIER (Check only one) 2 MEDICAL EXAMINER AND TITLE OF CERTIFICATION OF CERTIF | HOSPITAL: 1 Primpatient 2 E 28s. OATE OF IN. (Month, Dey. 28s. PLACE OF II be d 4 SICIAN: To the beet of my AINER: On the beet of exam | S. (Specify) NJURY — / knowledg | at home, ferm, a | 26. OTHER: 4 Nursing H E OF URY M 1 Intreet, factory, or at the time, or n, in my opinion | PLACE OF OEATH (Iome 5 Residence INJURY AT WORK? YES 2 NO fflice late end place, end con, death occured at the | Check only one 6 Other 28d. OESt 291. LOCA City o | PERFOI 1 YES : (Specify) (Specify) TION (Street r Yown, State | and Number | CUREO or Flural Flo ed. as couse(e) | OF DEATH? 1 YES 2 NO Butte Number, and menner as stated |
| COMPLETED BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICA EXAMINER? 1 | HOSPITAL: 1 Pinpatient 2 E 28a. OATE OF IN. (Month, Dey. On 28a. PLACE OF II be did building, etc. HYSICIAN: To the best of my MINER: On the best of exam WHO COMPLETED CAUSE | S. (Specify) NJURY — / knowledg | a, death occurre | 25. OTHER: 4 Nursing H EOF 28c. URY M 1 [street, factory, o | PLACE OF OEATH (lome 5 G Residence INJURY AT WORK? YES 2 NO ffice late end place, end of n, death occured at 1 29 LICENSE N | Check only one 6 Other 28d. OESC 291. LOCA City of the time, date | PERFOI 1 YES : (Specify) (Specify) TION (Street r Town, State see(e) end me seed) end me seed place, e | INJURY OCC and Number and out to the | or Rural Ro | OF DEATH? 1 YES 2 NO oute Number, and menner as state |

OHMH-16 Rev 1/89

| TO THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mous after death. Page 6 may be retained by the hospital of attending physician. To THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the mourial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Doct. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or tiem 23 shows any injury, or other traumatic event, the medical examiner must be note. | - | J. | -transit permit. Pages 1, 2, 3 should | | |
|--|---------------------------------|--|--|-------------------|--|
| | DALLIMORE, MARITANIO 21202-2140 | 24 mours after death. Page 6 may be retained by the hospital or are now, thysi | y filled in by the funeral director, page 5 should be detached for treatment nuria | tion, or removal. | the medical examiner must be notified at once. |

2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR SARAH WIENNER 12-7 -90 735 (SARAH WIENNER) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 1 M 2 X F DEC.25,1905 215-24-1515 RUSSIA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALTIMORE COUNTY GEN. HOSPITAL RANDALLSTOWN BALTIMORE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MARYLAND BALTIMORE OWINGS MILLS 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10n, CITIZEN OF WHAT COUNTRY? HIAWATHA CT., APT. F 21117 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No- RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, etc.)

1 YES 2 X NO Specify: 1 Never Married 2 Married Specify: WHITE В 3 Wildowed 4 Divorced 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY 18a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade completed) ost of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (0-12) Collega (1-4 or 5+) AT HOME COMPL 8 HOUSEWIFE 17. FATHER'S NAME (First, Middle, Last)
DAVID KAPLAN 18. MOTHER'S NAME (First, Middle, Malden Surname, IDA UNKNOWN 190. INFORMANT'S NAME (Type/Print)
MR. SAUL WIENNER MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9026 ALLENSWOOD RD. RANDALLSTOWN, MD 2 21133 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 2 Cremetion 3 Removal from State OHR KNESSETH ISRAEL ANSHE SFARD BALTIMORE, MD 4 Donation 5 Other (Specify). 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS, INC. Luck 6010 REISTERSTOWN RD. BALTIMORE, MD 21215 23 PART I. Enter the dissases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each lins. Interval Between Onset and Death IMMEDIATE CAUSE (Final Cardio vascular Disease disasas or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) betes mellet a CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate as lun cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 TYES 2 NO 1 - YES 2 00 PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) EXAMINER? 1 TES 2 TO OTHER: Inpatient 2 - ER/Oulpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident Investigation 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28s. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 🗌 Sulcida 8 Could not be COMPLETED 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data and place, and due to the cause(e) and manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, dasth occured at the lime, data and piece, and due to the cause(a) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month. Day, Year) BE 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typs, Print) D36456 0 9 Kiem Ong Baltimer County nFC 11 1990 SAN REGISTRARIS SIGNATURE LANG.



| | | | EKHE | ICATE OF | DEATH | RE | G. NO. | | |
|--|--------------------------|-------------------------------------|--------------|--------------------------------------|-------------------------|-----------------------------------|-----------------|---------------|--|
| 1. OECEDENT'S NAME (First, Middle, Las | 4) | | | | | 2. OATE OF DE | EATH DAY | YEAR | 3. TIME OF DEATH |
| I.INDA | L. | | 71 | EMBOWER | | 12-4-9 | | TEAH | 3:00 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. la | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | RTH | 8. B/R | THPLACE (State or Foreign |
| 201-38-8459 | 1 🗆 M 2 😿 F | 43 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, | | Pa | intry) |
| 9e. FACILITY NAME (# not institution, giv | e street and number) | 1 | | 9b. CITY, TOWN | OR LOCATION OF | | | . COUNTY OF | |
| Cumberland Memor | ial Hospi | ital | | Cumber | land | | | Alleg | |
| Cumberland Memori RESIDENCE OF DECEDENT 100. STATE 100. COU | ITY | | 10c. CIT | Y, TOWN OR LOC | ATION | | | | 10d. INSIDE CITY LIMITS? |
| | lford | | Bec | lford | | | | | 1 YES 2 NO |
| 10e. STREET AND NUMBER 527 S. Richo 11. MARITAL STATUS 1 Never Merried 2 S Merried | - 11 | | | 1 | Of, ZIP CODE | | 100 | g. CITIZEN OF | WHAT COUNTRY? |
| 527 S. Richa | urd St. | | | | 15522 | | | USA | |
| 11. MARITAL STATUS | 12. WAS DECEDE | NT EVER IN U.S. A | RMED | | CENDENT OF HISP | | | | ACE — American Indian, ack, White, atc. |
| 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | | 1 YES 2 X | NO | | S 2 NO Spec | | etc.) | | ocity: White |
| 15. OECEDENT'S E (Specify only highest grant property) Elementary/Secondary (0-12) 12 17. FATHER'S NAME (First, Middle, Last) | | 16a. D | ECEOENT'S | USUAL OCCUPATION Work done during it | TION nost of working | 16b. KIND | OF BUSINES | SS/INDUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | 5+) | e. Do NDT u | se retired.) | | | | | |
| 12 | Z | | Admer | ristrato | _ | | rsing | | |
| | udia | | | | | AME (First, Middle, | | emė) | |
| Hubert Le | yalg | 1 | Ob MAII IN | ADDRESS /Stone | and Number or Rura | Marie | | ete 7in Codel | |
| John W. Zembo | ou)o h | , | | | ard St., | | | | 22 |
| 20e. METHOD OF DISPOSITION | | 20b. PLACE | OF DISPO | | emetery, crematory or | | | ON — City or | |
| 11/2 Burlal 2 Cremation 3 Re 4 Donation 5 Other (Specify) | amoval from State | Red | | Cemeter | II. | | Rodin | rd. Pa | |
| 21. SIGNATURE OF FURERAL SERVICE | LICENSER | | 40.00 | 22. NAME | AND ADDRESS OF I | FACILITY | | -111 | |
| Jameth a.V | Berkele | le | | | thy A. B | | | | |
| 23. PART i. Enter the diseases, t | or complications th | at caused the d | leeth Do | | S. Julia | | | | Approximate |
| ahock, or heart failur iMMEDIATE CAUSE (Final disease or condition resulting in death) | . I Int make one or | | | | n of her | | | | interval Between Onset and Death |
| 2 | b. OUE TO | GE U | 1 MG | endera | P her | eg for | 0 | | |
| Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO | O OR AS A CONSI | EQUENCE | P): | 7 | | | | |
| CAUSE (Disease or injury | C | | | | | | | | |
| that initiated events resulting in death) LAST | DUE T | O (OR AS A CONSI | EUUENCE (| PF): | | | | | |
| i i i i i i i i i i i i i i i i i i i | d | | | | | | | | 1 |
| | one contributing t | to death but not | resulting | in the underly | ng cause given i | n Part i. 24a. | WAS AN AUT | | 24b. WERE AUTOPSY FINDINGS |
| PART II. Other eignificant condit | | | | | | | PERFORMED | 25 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | '□ | YES 2 | МО | OF DEATH? |
| E | | | | | | — | | 1 | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | | 28 | PLACE OF DEATH (| Check only one) | | | |
| EXAMINER? | HOSPITAL: | □ EB/Out==41=1 | 2 🗆 554 | OTHER: | | | - 4 - | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF OBATH | 28a. DATE C | ☐ ER/Outpatient | 3 L DOA | | ome 5 Residenc | e 6 ☐ Other (Spe 26d, DE\$CRIB | | BY OCCUPED | |
| I Harman 2 Laurund | (Month, | Day, Year) | IN | JURY | YORK? | zeu. Deșchia | E HOW INSU | NT OCCURED | |
| 2 Culatda — | 26e. PLACE | OF INJURY - At P | nome, farm, | street, factory, of | fice | 28f. LOCATION | (Street and I | Number or Rur | rel Route Number, |
| 1 4 Homicide determined | | at are (absony) | | | | City or Tox | VII, State) | | |
| | VSICIAN: To the heat | of my knowledge, o | death occur | red at the time, d | ite end plece, end d | us to the cause(s | and menner | as stated. | |
| 29e. CERTIFIER 1 CERTIFYING PH | 1 910thert, 10 tile nest | | | | | | | | se(e) and menner as stated. |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PH | | examination and/o | r investigat | on, in my opinion | | | prince, area ac | | |
| | INER: On the basic of | examination and/o | r Investigat | on, in my opinion | 29c. LICENSE N | | | | IED (Month, Day, Year) |
| 296. SIGNATURE AND TITLE OF CERTI | INER: On the basic of | examination and/o | r Investigat | | | UMBER | | | |
| 296. SIGNATURE AND TITLE OF CERTI | INER: On the basic of | hben | 1 | 10 | 29c. LICENSE N | UMBER | | | |
| 296. SIGNATURE AND TITLE OF CERTIFICATION 30. NAME AND ADDRESS OF PERSON Dr. Figueroa Me | FIER WHO COMPLETED CA | hben wse of OEATH (TT ospital | А мес | e, Print) | 29c. LICENSE N D 264 | УМВЕ В 71 | 29 | | MED (Month, Day, Year) |
| (Check only 1 CERTIFYING PROTECTION OF PROTECTION OF PERSON 29b. SIGNATURE AND TITLE OF CERTIFUE OF PERSON 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CA | hben use of OEATH (IT OSDITAL | А Мес | e, Print) | 29c. LICENSE N D 264 | УМВЕ В 71 | 29 | DATE SIGN | MED (Month, Day, Year) |



44 4 - 24 34 200 2011 1 of the editor? CAN SERVICE ASSESSMENT VIEW VIEW

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2, Jours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|
|--|

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | | HEALTH AND I | MENTAL HYGII | -14- | 34077 |
|---------------|--|--|----------------------------|-------------------|--|---------------------------------------|----------------------------|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | FRANK E. | AKCZ | INSKI | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH |
| | FRANK | E. AKCZI | NSKI | | | 12 | 4 199 | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (I | n yrs. last birthday) | | | 7. DATE OF BIRTH (Month, Day, Year | 8. | BIRTHPLACE (State or Foreign Country) |
| | 214-44-1715 | 1 📉 M 2 🗆 F | 47 YRS. | MONTHS DAY | S HOURS MIN. | 1 . / | 2 M | ARYLAND |
| | 9e. FACILITY NAME (If not institution, give str | set and number) | | 9b. CITY, TOW | N OR LOCATION OF DE | EATH | 9c. COUNTY | OF DEATH |
| DIRECTOR | UNIVERSITY HOSP | ITAL | | BALT | IMORE | | | |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b, COUNTY | | 10c. CI | ry, town or Lo | CATION | | | 10d. INSIDE CITY |
| Ę I | PA. NEW | PARK | | ., | | | | LIMITS? |
| | 10e. STREET AND NUMBER | ANN | | 1 | 101, ZIP CODE | | 10a, CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | RD 1 BOX 219 | | | | 17352 | | US | |
| N N | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS | DECENDENT OF HISPAN | NIC ORIGIN? (Specify | Yes or No- 14 | RACE — American Indian. |
| | 1 Never Merried 2 Merried | FORCES? 1 1 YES | 2 NO | If yes | specify Cuben, Mexica YES 2 NO Specific | n, Puerto Rican, etc.) | | Black, White, etc. Specify: |
| ВУ | 3 Widowed 4 Divorced | VI | ETNAM | | | | | WHITE |
| ED | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION completed) | 16a. DECEDENT'S | Work done during | | 16b. KIND OF | BUSINESS/INDUS | TRY |
| 9 | Elementery/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT L | retired.) | | | | |
| COMPLET | 11 YEARS | | TRUCK | DRIVE | | | LES | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 5.24 | ME (First, Middle, Mai | den Surname) | |
| BE | FRANK AKCZINS | KI | | | IRENE | MACEK | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | 7 T NICL/ T | | | eet end Number or Rural | | | |
| | MRS. IRENE AKC | | | | Cometery, cremetory or | | LOCATION - CIN | |
| | 1 💢 Burial 2 🗆 Cremation 3 🗆 Remo | val from State | other place) | SARV C | EMETERY | | LTO. C | |
| | PURCHATURE OF FUNERAL SERVICE LICE | | OLI INO. | | | | | |
| (| Karles Fac | seconsk | i | 252 | | ST. BAL | .TO. MD | . 21224 |
| | 23. PART i. Enter the diseases, or or shock, or heart influes. L | mplicationa that caused and only one cause on a | tha daeth. Do ach ilna. | not enter tha | moda of dying, suc | h aa cardlac or n | apiretory arrest | t, Approximate interval Between Onset and Death |
| | disease or condition resulting in death) | Opposite | lucius | Sea | er's | | | 48 hrs |
| | resulting in account | DUE TO (OR AS A | CONSEQUENCE | OF): | 7. 4 | | | |
| Z | Securettally the conditions of b | DUE TO (OR AS A | topenie | a. | | | | 3 doin |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE | DF) : | | | 1 | |
| [호 | cause. Enter UNDERLYING CAUSE (Disease or injury | Metasta | CONSEQUENCE (| avcin | oma, u | lukurun | Luna | ery Marths |
| Ē | that initiated events resulting in death) LAST | DUE TO (UN AS A | CONSEQUENCE | Jr): | | | | 0 |
| 9 | | l+ | | | | | | |
| | PART II. Other algnificant conditions | contributing to death b | ut not resulting | in the under | ying ceuse given in | Part I. 24s. WAS | AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICAL | Spinal Cord | & Compre | enins. | | | | FORMED? | COMPLETION OF CAUSE OF DEATH? |
| Ä | | V | | | | | | 1 TES 2 NO |
| | | | **** | | | | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 21 | B. PLACE OF DEATH (C) | neck only one) | | |
| Sign | 1 TES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outp | oationt 3 🗆 DOA | OTHER: | Home 5 - Residence | 8 Other (Specify) | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. Ti | ME OF 28c. | INJURY AT WORK? | 28d. DESCRIBE HO | W INJURY OCCUP | RED |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| ED 6 | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, | street, factory, | office | 281. LOCATION (Str City or Town, S | eet end Number or tate) | Rural Route Number, |
| E | 4 Homicide determined | | | | | | | |
| 급 | | CIAN: To the best of my know | ledge, death occur | rred at the time, | date and place, and du | e to the cause(e) end | manner as stated | |
| COMPLET | | R: On the basis of axamination | n and/or investigat | lon, in my opinic | on, death occured at the | time, data and place | a, and due to the o | ceuse(a) and manner ee stated. |
| Ü | 29b. SIGNATURE AND TITLE OF CERTIFIER | 4 | | | 29c. LICENSE NU | MBER | 29d. DATE S | IGNED (Month, Day, Year) |
| 8 | Richard D. | Patter m | 2 | | 0396 | 509 | 1 | 2/4/90 |
| 121 | 30, NAME AND ADDRESS OF PERSON WHO | | | | 2016 | J - 1 | | + + - |

225 Greene St.



30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print)

R. Potten, MD Win. H. Sp. tal. 2225 G

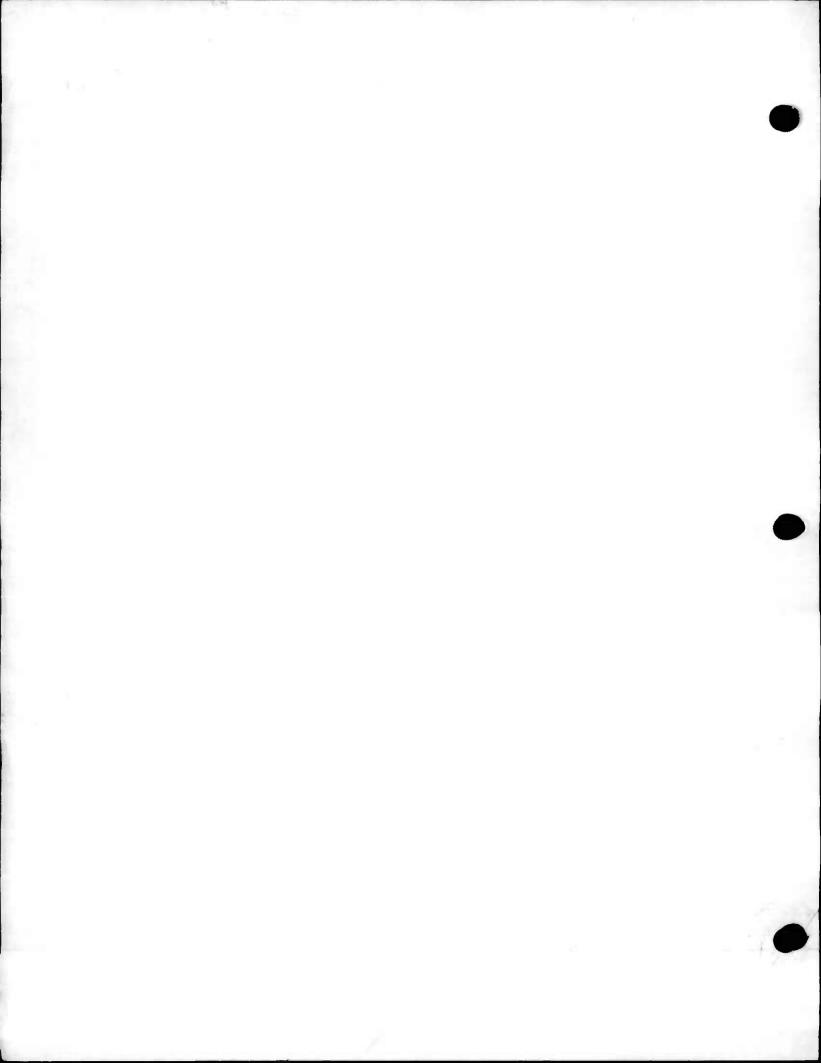
31. DATE FILED (Month. Day, Hart)

Se. REGISTRAR'S SIGNATURE

R. Patten, mo

nu

Baltmore,



TO BE COMPLETED BY FUNERAL DIRECTOR

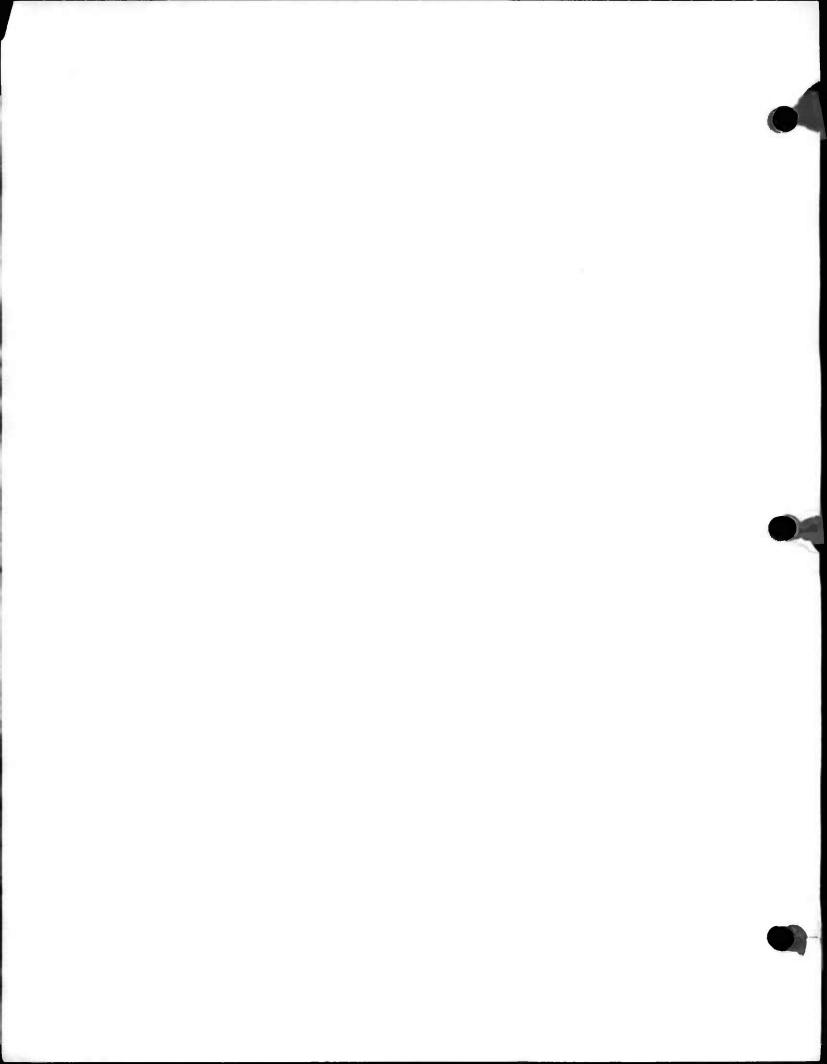
| מונים וויסוור, שמוובמו | wours after death. Page 6 may be retained by the hosp | illed in by the funeral director, page 5 should be detached, or removal. | e medical examiner must be notified at once. |
|--|--|---|--|
| DIVISION OF VIOLE MECCANDS, F.C. ECA. 13145, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache he fine within 72 hours after death with the State Debt. of Health and Mental Hydlene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | 90 | 34078 |
|---|----|-------|
| CERTIFICATE OF DEATH REG. NO. | | |

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAN | D / DEPARTM CERTIFIC | | | MENTAL HYGIEN REG. NO. | | 34078 |
|--|--|--|-------------------------------|--------------------------------|---|---------------|---|
| 1. DECEDENT'S NAME (First, Middle, Le CLARA M | BROWN CLARA | MAE BROW | ľΝ | | 2. DATE OF DEATH MONTH | Y 90 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 219-22-5217 | 1 DM 24 F | YRS. MO | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 23, | 1929 | MATYLACE (State or Foreign Maryland |
| 98. FACILITY NAME (If not institution, go | PITAL | 91 | DWS 0 | LOCATION OF DE | MD. | BAL BAL | OF DEATH |
| 10e. STATE 10b. COU | nty timore | | own or location | ON | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | | OF WHAT COUNTRY? |
| 57 Belfast Rd. 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U. FORCES? 1 YES : | 2 NO | 13. WAS DECE | | IIC ORIGIN? (Specity Yea n, Puerto Ricen, etc.) | | • RACE — American Indien, Black, White, etc. Specify: White |
| 15. DECEDENT'S (Specify only highest g Elementary/Secondary (0-12) 12 | | (Give kind of work life. Do NOT use no Homemak | k done during mos etired.) | N t of working | Own Ho | SINESS/INDUST | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | | |
| Edward R. Ehman, 190. INFORMANT'S NAME (Type/Print) | or. | 19b. MAILINO AD | ODRESS (Street an | | M. Snyder Route Number, City or Tow | | (e) |
| Joseph A. Brown, | Sr. | Same a | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 1 4 Donation 5 Other (Specify) | Remitted from State / 00 | LACE OF DISPOSITI | | | | to., M | · · |
| 21. SIGNATURE OF FUNERAC SURVICE | | | 22. NAME AN | Towson | | me, In | с. |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | e. DUE TO (OR AS A CO | ONSEQUENCE OF): | LLAR | Acc | DENT | | Interval Between Onset and Death |
| PART II. Other significant cond | dd. | not resulting in | tha underlying | cause given in | Part I. 24a. WAS AN PERFO! | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICA EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Ch | eck only one) | | |
| 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | ent 3 DOA 4 | OF 28c. INJU | JRY AT RK? | 6 Other (Specify) 28d. DE\$CRIBE HOW | INJURY OCCUR | ED |
| 2 Accident Investigat 3 Suicide 8 Could no 4 Homicide determine | 28s. PLACE OF INJURY — building, stc. (Specify, | At home, farm, stre | eet, factory, office | | 281. LOCATION (Street City or Town, State | | Rural Route Number, |
| one) | HYSICIAN: To the best of my knowled | | | | | | puse(e) end menner as stated. |
| 28b. SIGNATURE AND TITLE OF CERT | Houst Pines | | | 29c. LICENSE NUI | 20 | ► 12 | GNED (Month, Day, Year) |
| 31. DATE FILED (Month, Day, Jean) | 52. REGISTRATS SIGNAT 2 1990 Fulia Da | Mark Monk | 7620 | YORIC K | as Tows | m M | 124264 |





T.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

Borkowicz

90

YEAR

2. DATE OF DEATH

12-10-90

34079

3. TIME OF DEATH

5:55PM

| ā | VISION | OF VITA | DIVISION OF VITAL RECORDS, P.O. BOX 13146, | S, P.O. | 30X | 13146, |
|---|--------|---------|--|---------|-----------|-----------------|
| | | | The state of the s | A | and about | mindely bearing |

7. DATE OF BIRTH (Month, Day, Year 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 5. SEX 8. BIRTHPLACE (State or Foreign DAYS HOURS 6-10-43 1X X4 2 | F 47 YRS. MARYLAND permit. Pages 1, 2, 3 should 9a, FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 848 Mangold Street Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND 1 YES 2 NO BALTIMORE FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit at. of Health and Mental Hygiene prior to burial, cremation, or removal. I shows any injury, or other traumatic event, the medical examiner must be notified at once. UNKNOWN USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puerlo Rican, atc.)

1 YES 2 NO Specify: FORCES? 1 YES 2 1 Never Married 2 Merried Specify: WHITE BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 166 KIND OF BUSINESS/INDUSTRY (Specify only high most of working YEARS College (1-4 or 5+) SOLDERER HAHN CO 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) SOPHIE BAUERS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING AODRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 MR. THOMAS BORKWITZ 3314 HARMONY COURT BALTO. MD. 20e. METHOD OF DISPOSITION
1 Neuriel 2 Cremation 3 Removal from State 20b. PLACE OF OISPOSITION (Name of cometery, crematory or 20c. LOCATION - City or Town, State STANISLAUS CEMETERY 4 Donetion 5 Other (Specify) BALTO. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME lamma 2525 FLEET STREET BALTO 21224 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximata ahock, or hasrt failure. List only one cause on each line. interval Batwaar **Onset and Death** IMMEDIATE CAUSE (Final disease or condition a. Pneumonia resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, lasding to immediata cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE Fatty Liver; Arteriosclerotic cardiovascular disease 1 XXES 2 INO OF DEATH? XX YES 2 □ NO certificate has been the State Dept. of the State Dept. of tem 23 st PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL OTHER: 1 | Inpatient 2 | ER/Outpetient 3 | DOA XIX YES 2 NO g Home 5 Residence 8 - Other (Specify) PHYSICIAN: 4 🗆 N marked, or 27. MANNER OF DEATH 28e. DATE OF INJURY 28c. INJURY AT WORK? 28b. TIME OF INJURY 28d, DESCRIBE HOW INJURY OCCURED with this 1 Natural 5 Pending M 2 NO 1 YES HOSPITAL DR ATTENUM.

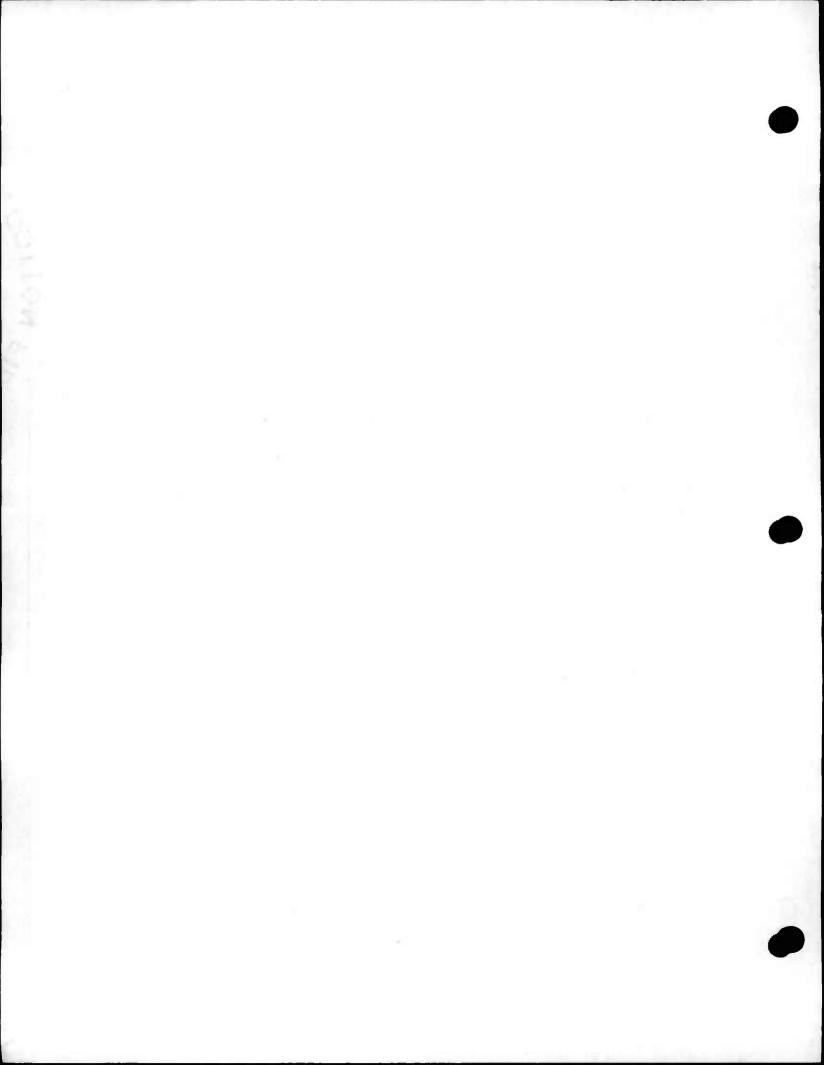
A.E. FUNERAL DIRECTOR: After 7 and within 72 hours after death within 18 is m After t В 2 Accident Investigation 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 8 Could not be determined COMPLETED 4 Homicide TO THE HOSPITAL DR ATT TO THE FUNERAL DIRECT De filed within 72 hours at IMPORTANT: If Item 2 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occured at the time, data end place, and due to the ceuse(s) end manner as stated. 290 THOMATURE AND TITLE OF CENTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCME 12-11-90 2 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Balimore, MD 21201 FRANK PERETTI, MD 31. DATE FILED (Month, Day, Year)
DECL 3 1990 32 REGISTRAR'S SIGNATURE OHMH-18 Rev 1/89

nours after death. Page 6 may be retained by the hospital or attending physician. ë that equires

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last) KENNETH

Kenny



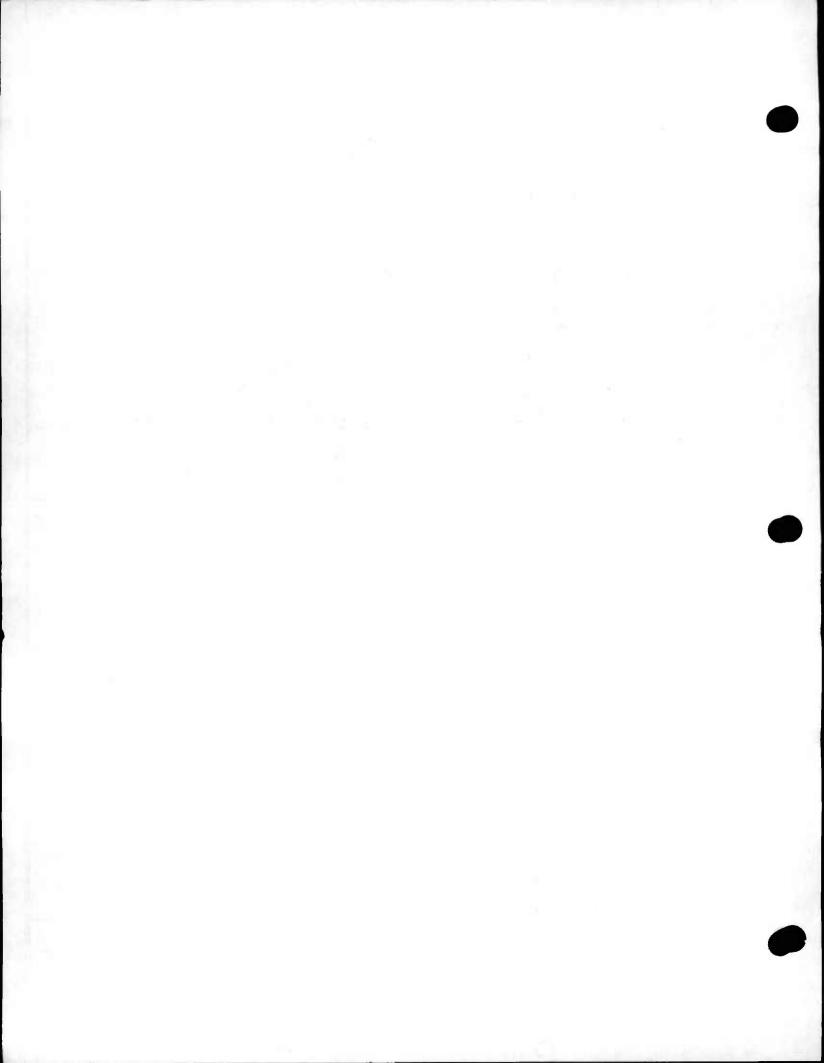
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within c.v. nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
|---|
| IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notitled at once. |
| |

| | FOR STATE REGISTRAR | | STATE OF I | MARYLAND | / DEPAI | RTMENT | OF H | EALTH | AND | MEN | ITAL HYGIEN | E 9 | 0 | 34080 | |
|---|---|--------------------------------|-------------------------|--|--|----------------|--------------|-----------------|--------------------------|---------|---|-------------|-----------------|--|---------------|
| | 1, DECEDENT'S NAME (First, | , Middle, Last) | | | | | | | | | DATE OF DEATH | | (| 3. TIME OF DEATH | |
| 1 | ESTHER M. | BARRE | ETT | | | | | | | ľ | EC.10,19 | 90 | YEAR | 12:15 A. 1 | ММ |
| - 9 | 4. SOCIAL SECURITY NUME | BER | 5. SEX | 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | | | | | | 7. 0 | ATE OF BIRTH | | 8. BIRTI | IPLACE (State or Foreign | $\overline{}$ |
| | 212-74-29 | 87 | 1 □ M 2 🔯 F | M 2 K F 90 YRS. MONTHS DAYS HOURS MIN. | | | | | MIN. | | Month, Day, Year) JLY 30,19 | 200 | M A I | RYLAND | |
| | 9a. FACILITY NAME (If not in | | lreet and number) | | | 9b. CITY | , TOWN C | R LOCATI | ON OF D | | JET 30,13 | | NTY OF D | | _ |
| Œ | CANTON HA | RBOR N | URSING H | OME | | | BALT | IMOE | RE | | | _ | | _ | |
| 81 | RESIDENCE OF DEC | | | | | | 21121 | | | | | | | | |
| H | 10a. STATE | 10b. COUNT | Υ | | 10c. Cl | TY, TOWN C | OR LOCAT | TON | | | | | | 10d. INSIDE CITY LIMITS? | |
| ā | MARYLAND | | | |]] | BALTI | MORE | 2 | | | | | | 1 X YES 2 - NO | |
| FUNERAL DIRECTOR | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | DDE 10g. CITIZEN OF WHAT | | | | | WHAT COUNTRY? | |
| E | 3606 ROBERT | S PLAC | CE | | | | | | 212 | 24 | | U | . S. | Α. | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDED | T EVER IN U.S. A | ARMEO | 13. | WAS DEC | ENDENT (| OF HISPA | NIC O | RIGIN? (Specify Year erto Rican, atc.) | or No- | 14. RAC Blac | E — American Indien, k, White, etc. | |
| BY | 1 Never Married 2 3 X Widowed 4 Divo | | IF YES, GIVE | MAR OR DATES | 2.10 | | | 2 NO | | | erio riicani, etc.) | | Spec | ity: | |
| | | | | | | | | | | | | | | WHITE | |
| Ī | | EOENT'S EOU y highest grade | completed) | | DECEOENT'S (Give kind of Vie. Do NOT I | work done | | | ing | | 16b. KINO OF BUS | SINESS/INC | DUSTRY | | |
| الإ | Elementary/Secondary (0 | 3-12) | College (1-4 or 5 NA | +} | IOMEMA | | | | | | OLDNI 7 | IOME | | | |
| COMPLETED | | | IVA | | OMEMA | ANEK | | | | | OWN H | | | | |
| | 17. FATHER'S NAME (First, M SAMUEL THOM | | | | | | | | | | First, Middle, Maiden | | | | |
| 19a. INFORMANT'S NAME (Type/Print) JESSE T. BARRETT (SON) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 DAYWALT AVE, BALTIMORE, MD. 21206 | | | | | | | | | · | | | | | | |
| | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| | 20s. METHOO OF DISPOSIT | on 3 🗆 Rem | noval from State | other | place) | | | | matory or | | | | | | |
| - 1 | 4 Donation 5 Other | | revers / | | AKLAV | | | RY ND ADDRE | TOP OF F | AOU IT | IBALI | IMOR | E. M | D. | _ |
| | II. SIGNATURE OF FURGO | L SCHILL LI | // | | | | | | | | AL HOMES | . IN | C. | | |
| | 1 /huan | | Trais | | | | | | | | E, BALTI | | | . 21213 | |
| | 23. PART I. Enter the d | | complications th | | | not enter | the mo | de of dy | lng, su | ch ee | cardlac or respi | retory an | reat, | Approximete | |
| | IMMEDIATE CAUSE (FI | | List only one ca | use on each ii | ne. | | | | | | | | | Interval Betwee | |
| - 1 | disease or condition resulting in death) | → | - 351 | 1,50 | | | | | | | | | | | |
| | resoluting in dealth) | | DUE TO | O (OR AS A CONS | SEQUENCE | OF): | | | | | | | | | |
| 2 | | | , AJ | ev0 | | | | | | | | | | | |
| 은 | Sequentially list condit if any, leading to imme | | DUE TO | OR AS A CONS | SEOUENCE | OF): | 4 | 0 | | | | | | | |
| 3 | cause. Entar UNDERLY CAUSE (Disease or Inju | | a Aru | O (OR AS A CONS | thelE | Cey for | hi | , 6 | 40 (x. | left | 4 | | | | |
| E | that initiated events | | DUE TO | O (OR AS A CONS | SEQUENCE | OF): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAS | ST | d | | | | | | | | | | | | |
| | PART II. Other eignific | ent condition | ne contributing t | n death but no | t resulting | In the u | nderivin | o causa | alven la | n Par | t I. 24a. WAS AN | AUTOPSV | 24 | b. WERE AUTOPSY FINDIN | NGS |
| S | D'83- | | malle | h | | | | | 3 | | PERFO | | | MAILABLE PRIOR TO COMPLETION OF CAUS | |
| ă | 10) 10 17 | - | | 1 % | | | | | | | 1 🗆 YES 2 | DONO | | OF DEATH? | 7 |
| Σ | | | | | | | | | | | | | | 1 YES 2 NO | |
| ä | | | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED ' EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHE | | LACE OF | DEATH (C | check (| only one) | | | | _ |
| YS | 1 YES 2 NO | | 1 Inpatient 2 | | 7 | 1 / | | | Pesidence | _ | Other (Specify) | | | | |
| | 27. MANNER OF DEATH | Pending | 28a. DATE O (Month, | Day, Year) | 26b. I | ME OF NJURY | W | JURY AT ORK? | - 53 | 28 | d, DESCRIBE HOW | INJURY OC | CURED | | |
| ВУ | 2 Accident | Investigation | | | | | | YES 2 | □ NO | 1 | | | | | |
| | 3 Suicide 6 4 Homicide | Could not be determined | building | OF INJURY — At J, etc. (Specify) | home, ferm | , atreet, fac | ctory, offic | Ca | | 28 | f. LOCATION (Street City or Town, State) | | or Rural | Route Number, | - 1 |
| ET | | | | | | - | | | | | | | _ | | _ |
| 4PL | CONDON UNITY | | SICIAN: To the bast | | | | | | | | | | | | |
| COMPLETED | 2 MEC | DICAL EXAMIN | ER: On the basis of | examination and/ | or investiga | tion, in my | opinion, | death occ | ured at th | ne time | e, data and place, a | nd due to t | the cause | (a) and menner as state | d. |
| BE C | 29b. SIGNATURE AND TITL | E OF CERTIFIE | VVI | | - | | | | CENSE N | | | | | O (Month, Day, Year) | |
| | | | 1/1 | | | | | 1 |) 2 y | 27 | 6 | D 1 | 2.1 | 0-90 | |
| 5 | 30. NAME AND ADDRESS (| DE PERSON W | HO COMPLETED CA | USE OF OFATH (| TEM 27) /% | ne Printi | | | | | | | - | | |

DR. SIMON SCALIA, 2900 E. BALTIMORE ST., BALTIMORE, MD. 21224

32. REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day, Ybar)



Pages 1, 2, 3 should

permit.

burial-transit

) by the funeral director, page 5 should be detached for use as the removal.

9

signed by the attending physician and completely fille Health and Mental Hyglene prior to burial, cremation,

DIRECTOR: After this certificate has be hours after death with the State Dept.

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | OCCITAL OD ATTENDAME BUNCHCIAM. The law consists that the death certificate he exercited within |
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| | OCBITAL |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR Elizabeth B1351 H 0730 A M 09 17 990 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 1/22/19 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 82-14-8839 Maryland MONTHS DAYS HOURS MIN. 1 - M 2 F YRS. 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR BALLMINE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10d, INSIDE CITY LIMITS? MD Baltimore 1 VES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1501 Dukeland Street 21215 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES X 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married 1 TES 2 NO Specify: BY 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) DOROTHY ELIZABETH notified at PAUL HAVARD 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda Lessner SocWk Liberty Medical Center Balto examiner must be 20b. PLACE OF DISPOSITION (Name of cometery, cremetery or 20c. LOCATION - City or Town, State STATE ANATOMY BOARD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir medical 23. PART I. Exter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate IMMEDIATE CAUSE (Final **Onset and Death** the the disease or condition resulting in deeth) Cardiac Arrest event, DUE TO (OR AS A CONSEQUENCE OF) Severe Chronic Obstructive Pulmonary Disease Due to (or as a consequence of): traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING Pneumonia CAUSE (Disesse or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST Item 23 shows any Injury, PART II. Other significant conditions contributing to deeth but not reaulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 ☐ YES 2 ☐ NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 inpution 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 YES 2 NO 6 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 25b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28 is marked, 1 Natural 5 Pending Investigation 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 5 Could not be 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. COMPL 2 MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 띪 Lukever, mD 12/9 74095 2 ESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ndukwy, mp TKeadi Liberty Medical Center 32 HEBISTRAM'S SIGNATURE PANDAR

3. TIME OF DEATH

REG. NO

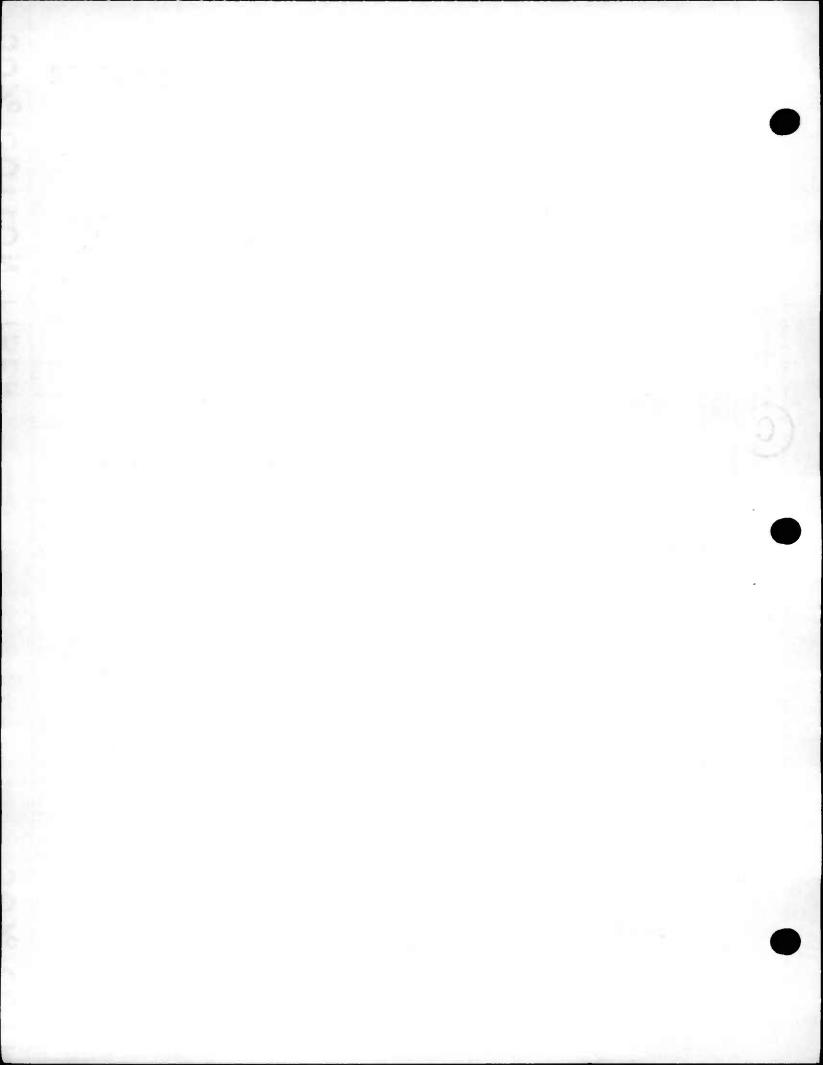
2. DATE OF DEATH

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z4 hours after death. Page in the same to the hospital or attending physician. | |
|---|--|
| TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral control and the property of the control of the control of the attending physician and completely filled in by the funeral control of the control | |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

Anthony Frederic Beier 4:10 PM 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 12,10, 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Maris-Stella TOWSON DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD 1 YES 2 NO Baltimore FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 3800 The Alameda 21218 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if was, specify Cuban, Maxican, Puerto Rican, etc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexican, P 1 TES 2 NO Specify: 1 Never Merried 2 Married Specify: BY 3 Widowed 4 Divorced White WW TT LETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 12 = 4Engineer Merchant Marine 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) JAMES BEIERLEIN ALICE ELKINS BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mary Schiavo Niece 3800 The Alameda, Balto, MD 21218 20s. METHOD OF DISPOSITION
1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cornetery, crematory or 20c. LOCATION - City or Town, Stats N Donation 5 ☐ Other (Specify) 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 655 W. Balto.St., Balto., MD 21201 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** rostate Cancer disease or condition resulting in death) QUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE 1 TES 2 NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: Hospice 1 YES 2 NO 1 🗆 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Netural
2 Accident 5 Pending 1 YES 2 NO BY 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 027087 29d. DATE SIGNED (Month, Day, Year) BE ala Dalerandero 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M.D. - Stella Maris Hospice Dulaney Valley Rd. 21204 Alexander, Carla SE HEGISTRAS I SIGNATUREN CO



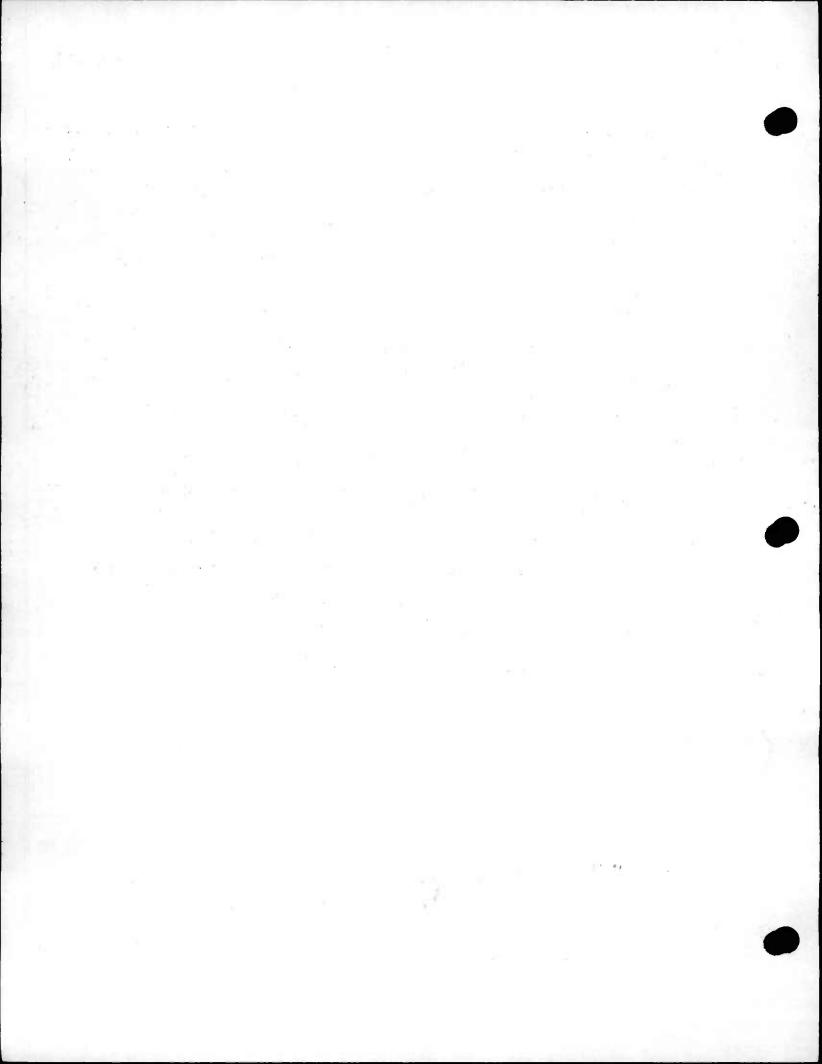
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL | HYGIENE REG. NO. |
|-----|---------------------------------------|---|-----------|---------------------|
| . 0 | DECEDENT'S NAME (First, Middle, Last) | | 2. DATE O | F DEATH |

| | REGISTRAR | CERTIFIC | ATE OF DEATH | REG. NO. | | |
|---------------|--|---|---|--|---|--|
| | 1, DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH DA | Y YEAR | 3. TIME OF DEATH |
| | Evelyn G. Biddle | | | 12 9 | 90 | 12:21 am |
| | 4. SOCIAL SECURITY NUMBER 6. SEX 6. A 205 22 2648 1 1 M 2 1/4FX | | UNDER 1 YEAR IF UNDER 24 HRS. NTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 7 - 13 - 192 | Count | HPLACE (State or Foreign lry) |
| | 9a. FACILITY NAME (If not institution, give street and number) | 98 | . CITY, TOWN OR LOCATION OF D | | 9c. COUNTY OF I | |
| HOL | Memorial Hospital | | Easton | | Tall | oot |
| DIRECTOR | 10a, STATE 10b. COUNTY MD | nderson | . <u> </u> | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| | 10s. STREET AND NUMBER | | 10f, ZIP CODE | | 10g, CITIZEN OF | |
| FUNERAL | PO Box 34 | | 21640 | | USA | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVI FORCES? 1 Y IF YES, GIVE WAR O | ES 2 NO | 13. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexica 1 YES 2 NO Specif | n, Puerto Rican, etc.) | or No- 14. RAC Blac Spec | E — American Indian, k, White, etc. |
| ا ۾ | 15. DECEDENT'S EDUCATION | 16a, DECEDENT'S US | JAL OCCUPATION | 16b. KIND OF BUS | INESS/INDUSTRY | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | (Give kind of work life. Do NOT use re | done during most of working | | | |
| ĭ ĭ | 17. FATHER'S NAME (First, Middle, Last) | | 40 MOTHERNO MA | ME (First, Middle, Maiden | | |
| | PAUL BECKER | | 111000 | KOONTZ | Surname) | |
| BE | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING AD | DRESS (Street and Number or Rural | Route Number, City or Tow | n, State, Zip Code) | |
| | 20s. METHOD OF DISPOSITION 1 | 20b. PLACE OF DISPOSITION other place) | ON (Name of cemetery, cremetory or | 20c. LO | CATION — City or T | own, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald | Wade.Dir | 22. NAME AND ADDRESS OF FA | CLITY STATE | ANATON | Y BOARD |
| | - Howlest ording | | 555 W. Balto | | | |
| | 23. PART I. Enter the discesses or complications that cer | used the deeth. Do not | enter the mode of dying, suc | h as cerdiec or respi | ratory arrest, | Approximate |
| | ahock, or heart tellure. List only one cause o | n eech line. | | de | | Interval Between Onset end Death |
| | resulting in desth) | as tibrilleti | ion and Torsadi | estointe pllo | winy vento | war ~2m/r |
| _ | Sequentially list conditions (b. My a Ca | SA CONSEQUENCE OF: | Infarction | | Tach | verdia, |
| ٥ | DAE TO (OR | AS A CONSEQUENCE OF: | · ~ | | | ~ lohas |
| ያ | cause. Enter UNDERLYING CAUSE (Disease or injury | ective the | art failure | | | days |
| | that initiated events DUE TO YOR | AS A CONSEQUENCE OF): | | 15 | | |
| CERTIFICATION | resulting in death) LAST | value Co | ronary Arter | y disease | | years |
| | PART II. Other aignificant conditions contributing to deel | th but not resulting in t | the underlying cause given in | Part I. 24s. WAS AN | | b. WERE AUTOPSY FINDINGS |
| EDICAL | Insulin Dependen | t Pialeter | Mellitus | PERFOR | | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| | Chronic Obstruction | | ary Disease | 1 1 TES 2 | , m | OF DEATH? |
| PHYSICIAN: M | | e painon | ary wisese | _ | | 1 - YES 2 NO |
| ¥ | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C/ | seck only one) | | |
| ᄗ | EXAMINER? HOSPITAL: | | THER: | | | |
| ¥ ا | 27. MANNER OF DEATH 28s. DATE OF INJU | | □ Nursing Home 5 □ Residence F 28c, INJURY AT | 8 ☐ Other (Specify) 28d. DEŞCRIBE HOW II | LILIEV COCHOED | |
| | Natural 5 Pending (Month, Day, Ye | er) INJUR | WORK? | 28d. DESCRIBE HOW I | NJUNT OCCURED | |
| m l | 2 Accident Investigation | URY — At home, farm, stre | | 044 1 004 71011 (01-1-1 | -11 | S-1-11-1 |
| COMPLETED | 3 Suicide 6 Could not be 4 Homicide determined | (Specify) | or, ractory, office | 261. LOCATION (Street a City or Town, State) | nd Number of Hural | Houre Number, |
| ן ק | 29a. CERTIFIER (Check only | nowledge, death occurred a | at the time, date and place, and due | to the cause(s) and mar | nner as stated, | |
| <u> </u> | one) 2 MEDICAL EXAMINER: On the basis of examin | | | | | (a) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER | | 29c, LICENSE NU | | | |
| 8 | 1 dd mes Harn | ma | D 351 | | 290. DATE SIGNE | 0 (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF | F DEATH (ITEM 27) (Type: Pr | | <i>- 1</i> | 12 | 1110 |
| | Monica Agr | ee; l | Denton, M. | 0;21 | 629 | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRUR'S: | SIGNATURE ACCORD | | , | | |

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | O THE HOSPITAL OF ATTENDING INTECAM TO requires that the death certificate be executed within 24 hour | THE FUNERAL DIRECTOR AND THE COMPLETE DEED SIGNED BY THE ATTENDING PHYSICIAN AND COMPLETELY filled in | 7 |
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| | FOR | STATE OF MAI | RYLAND / I | DEPAR | TMENT OF H | IFAITH AND I | MENTAL HYGIEN | 30 | 34004 | | |
|---|---|--|-------------------------------|-------------------|-----------------------------|--------------------------------|---|--------------|--|--|--|
| | 1 - STATE REGISTRAR | OIMIE OI IIIMI | | | CATE OF | | REG. NO. | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | BRY | An | JT | | 2. DATE OF DEATH MONTH | | 3. TIME OF DEATH 8 08 A M | | |
| | 4. SOCIAL SECURITY NUMBER 217 34 9691 | 5. SEX 6. | AGE (in yrs. last) | birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS, HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 40 | BIRTHPLACE (State or Foreign Country) Va • | | |
| œ | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Balto., Md. | | | | | | | | | | |
| 25 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIRECTO | 10c. CITY, TOWN BAILTIMOTE | | | | | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 123 W. 29th S | t. | | | 10 | ZIP CODE 2121 | 8 | | U.S.A. | | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 11. Never Merried 2 Merried 15. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. 14. Never Merried 2 Merried 16. Never Merried 17. Never Merried 17. Never Merried 18. Was DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No— 14. | | | | | | | RACE — American Indian, Black, White, etc. | | | | |
| BY BY | 3 Wildowed 4 X Divorced 1958 NO Specify: | | | | | | | *Black | | | |
| ETEC | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Sive kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | TRY | | | |
| College (1-4 or 5+) College (1-4 or 5+) | | | | | | | | | | | |
| 198, INFORMANT'S NAME (Type/Print) 198. MAILING ADDRESS (Street and Number or Rural Route Number. City or Town, State, Zio Code) | | | | | | | | Purvis | | | |
| | | | | | | | | Md. 21239 | | | |
| | 20sn METHOD OF DISPOSITION 1 Department 2 Crementon 3 Rem 4 Donetton 5 Other (Specify) | oval from Stata | 20b. PLACE Of other place | | SITION (Name of ce | metery, crematory or | 20000 | A/+D | or Town, State | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | 1 | 4 | 22. NAME A | ND AODRESS OF FA | orton & S | ons | 7110 | | |
| | James | a.m | Work |) | 1701 | Lauren | s St. Ba | lto., | | | |
| | 23. PART 1. Enter the diseases, or shock, or heert feliure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | List only one ceuse | on each iine. | | | | AL BL | | Interval Between | | |
| | resulting in death) | ALCOHOLIC LIVER DISEASE & COAGULOPATHY | | | | | | | | | |
| ATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): KLEBSIELLA SEPTICEMIA | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | AL FAI | | | | | | |
| CE | PART it. Other algorificant condition | | | | | | Part I. 24e. WAS AF | VAUTOPSV | 24b. WERE AUTOPSY FINDINGS | | |
| MEDICAL | PART II. Other algorificant condition CHRONIC | THRO | MBO | 64. | TOPEN | IA | PERFO | RMED | AVAILABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? | | |
| ME | | | | | | | | | 1 YES 2 NO | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL | 1 | | | 26. P | LACE OF DEATH (C) | heck only one) | | | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: | R/Outpatient 3 | □ DOA | OTHER: 4 Nursing Hor | me 5 🗆 Residence | & Other (Specify) | | | | |
| | 27. MANNER OF DEATH 1 ☑ Naturel 5 ☐ Pending | 28a. DATE OF IN. (Month, Day, | IURY Year) | 28b. TIN | JURY W | JURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCUP | RED | | |
| TED BY | 2 Accident Investigation 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF II building, etc | NJURY — At hor . (Specify) | ne, form, | street, factory, offi | ca | 281. LOCATION (Street City or Town, State | | Rural Route Number, | | |
| COMPLETED | one) | SICIAN: To the best of my | | | | | | | ceuse(s) and manner as stated. | | |
| BE | A - C 4 CHOW | (1) | . D . | | | 29c. LICENSE NU | IMBER | 29d. DATE S | SIGNED (Month, Day, Year) | | |
| 10 | A.C. CHONY | LIT, M. | OF DEATH (ITEM | 1 27) (Type | EWOO | D Hos | P. CENT | ER. | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 1 2 1990 | 32. REGISTRAR'S | - | | | | | | | | |



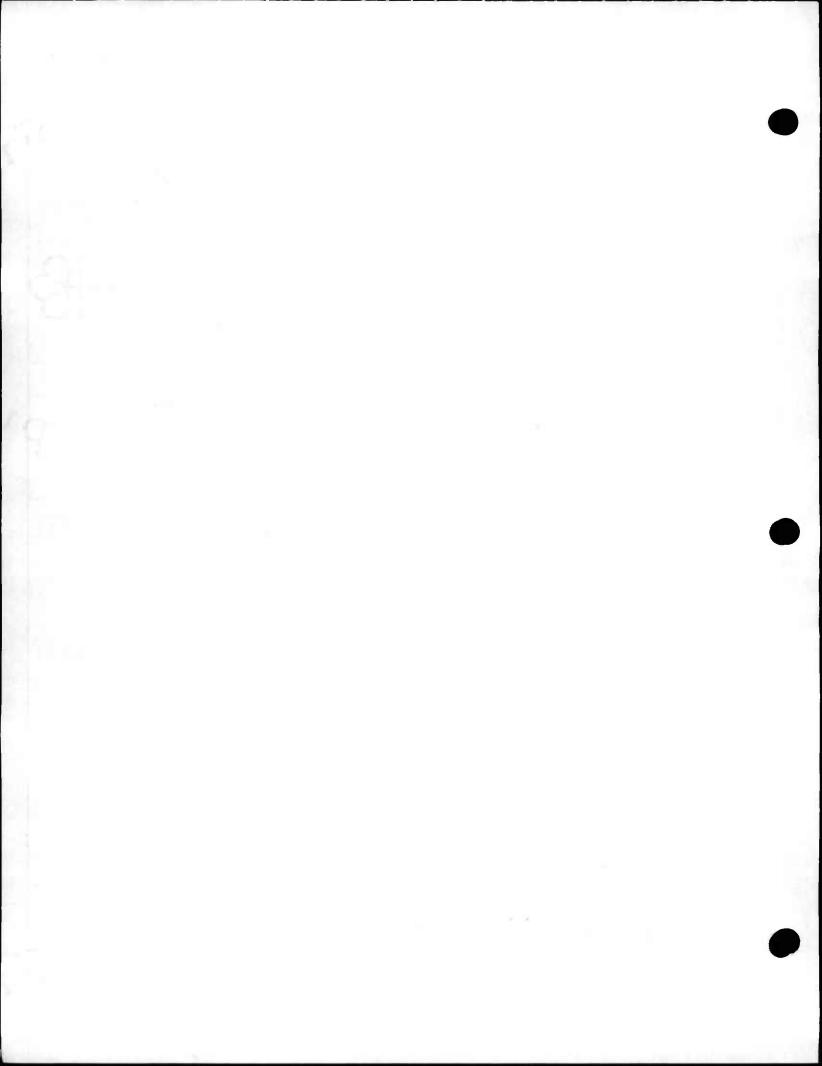
31. DATE FLED (Month, Day).
DEC 12

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| | FOR STATE REGISTRAR | STATE OF MARYLAND | / DEPAR | ITMENT OF | HEALTH AND I | MENTAL HYGIEN REG. NO | IE | | | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH D | AY YEA | 3. TIME OF DEATH | | |
| | Margaret Loyola | Carrigan | | | | 12 6 | 90 | М | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. in | ast birthday) | IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day, Year) | 6. B | INTHPLACE (State or Foreign country) | | |
| İ | 218-56-9851 | 1 □ M 2 👽 F 83 | YRS. | EVITTIE SIN | noona min. | 5/11/07 | | assachusetts | | |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | 96. CITY, TOW | N OR LOCATION OF DI | EATH | 9c. COUNTY | | | |
| OR | Villa Julie Infi | rmarv. | | Stev | renson | | Balt | to | | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | T soc CIT | TY, TOWN OR LO | | | | | | |
| DIRECTOR | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| | Maryland Bal 100. STREET AND NUMBER | lto. | 5 | tevenso | 10f. ZIP CODE | | T 100 CITIZEN | OF WHAT COUNTRY? | | |
| RA | | ** ** ** ** ** | | | | : 0 | | S.A. | | |
| FUNERAL | 1531 Greenspri | ing Valley Rd. | * 2450 | 1 12 1480 | 2115 | | | RACE — American Indian. | | |
| | 11. MARITAL STATUS 1 Lablever Married 2 Married | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | If yes, | , specify Cuban, Mexico | NIC ORIGIN? (Specify Ye an, Puerto Rican, atc.) | 1 2 | Black, White, etc. | | |
| B | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | יטי | YES 2 NO Specif | ty: | ' | Specify: White | | |
| 0 | 15. DECEDENT'S EDUC | | | S USUAL OCCUP | | 16b. KIND OF BU | ISINESS/INDUST | | | |
| E | (Specify only highest grade Elementary/Secondery (0-12) | College (1-4 or 5+) | (Give kind of ille. Do NOT u | work done during use retired.) | most of working | | | | | |
| P | 4 Teacher- Catholic Schools Education | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maider | Surname) | | | |
| | Tamag C | arrigan | | | Ma | rgaret 1 | Murphy | | | |
| BE | 10. INSCRIPTION AME (Frankfirst) 10. MAII INC ADDRESS (Street and Number of Burel Bords Number City or Tourn State 7th Code) | | | | | | | | | |
| 2 | Villa Julie | Infirmary | | S | ame as 10a | a | | | | |
| | 201 METHOD OF DISPOSITION | 20b. PLAC | E OF DISPO | | f cemetery, cremetory or | | OCATION — City | or Town, State | | |
| | 1 Burial 2 Cremation 3 Rem 4 Donation 5 There (Specify) | | place) | Dama Ce | metery 12 | /11/90 Ma | lden. M | /acc | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | DEVISEE / | 31.11- | 22. NAM | E AND ADDRESS OF F | ACILITY | • | | | |
| | DE 1001 | V.L. V | | | | | 0 York | | | |
| | LMau | neft soc | | | | Funeral Ho | | | | |
| | 23. PART'i. Enter the diseases, or a ahock, or heart failure. | complications that caused the List only one cause on each il | deeth. Do ine. | not anter the | mode of dying, suc | ch as cardiec or resp | piretory arrest, | Interval Between | | |
| | IMMEDIATE CAUSE (Final | A COUD | | 4 | 1.00 | 2 4 | Look | Onset and Death | | |
| | disease or condition resulting in desth) | 11001 | _ u | NU. | Con | esnue | reco | | | |
| | | DUE TO OH AS A CONS | 1 | , | 20 Miles | eshie | - 0 | | | |
| N | Sequentially list conditions, | b. DUE TO (OR AS A CONS | | inne | e 0 | user | ex_ | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CORS | SECUENCE O | A 8 | rency | -ang | omas | 0 | | |
| 길 | CAUSE (Disease or Injury | c. DUE TO OR AS A CONS | SECULENCE (| | The state of the s | | 2000 | | | |
| | that initiated events resulting in death) LAST | 552 10 (011 70 71 00110 | PEROLINOE O | <i>,,,</i> 0 | V | | | Ì | | |
| 岁 | | d | | | | | | 1 | | |
| . 1 | PART II. Other aignificant condition | na contributing to death but no | t resulting | in the under | ying ceuse given ir | | N AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| MEDICAL | | | | | | 1 □ YES | | COMPLETION OF CAUSE DF DEATH? | | |
| 밀 | | | | | | | | 1 YES 2 NO | | |
| = | | | | | | _ | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 2 | 6. PLACE OF DEATH (C | Check only one) | | | | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient | 3 🗆 DOA | OTHER: | Home 5 - Residence | 6 Other (Specify) | | | | |
| H | 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b. Til | IME OF 28c | L INJURY AT | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| | 1 Natural 5 Pending | (Month, Day, Year) | 100 | M 1 | WORK? | | | | | |
|) BY | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY — At | home, farm | , street, factory, | office | 28t. LOCATION (Street | t and Number or i | Rural Route Number, | | |
| 8 | 4 Homicide determined | building, etc. (Specify) | | | | City or Town, Stat | e) | | | |
| iu I | 29a. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my knowledge, | death occu | | date and place, and d | and the sequence and m | | | | |
| 3 | Oriota trity | | | | | | | euseis) and manner as stated | | |
| MPL | one) 2 MEDICAL EXAMINE | | | | | | THE OUT IN THE P | | | |
| COMPLET | 2 MEDICAL EXAMINE | ER: On the basis of examination and/ | /or investigat | tion, in my opini | | | | | | |
| BE COMPLE | 2 MEDICAL EXAMINE 29b. SIGNATURE AND TITLE OF CERTIFIE | | m | 7) | 29c. LICENSE M | | 29d. DATE SI | IGNED (Month, Day, Year) | | |

Hospital

Balto.



TO THE HOSPITAL OR AZTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. Are this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72-howe are death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

31. DATE FILED (Month, Day, Year)
DEC 12 1990

La Davidson-Randelle

| | 1 | - STATE REGISTRAR | SIAIE UF N | | ERTIF | | | | | MEN IVI | REG. NO. | | | |
|---|---|--|-----------------|--------------------------------|-----------------------------|-------------|--------------|------------------|-------------|------------------|-----------------------------------|-----------------------------|--------------------------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) ELLA CL | -OPEI | N | | | | | | 2. DATE MONTH | | | YEAR | 3. TIME OF DEATH |
| | I | | SEX | 6. AGE (In yrs. I | lasi birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | | OF BIRTH | | 6. BIRTH | PLACE (State or Foreign |
| | | 01 01/00 | ☐ M 2 💢 F | 78 | YRS. | | | | | | 10-12 | | | Md. |
| OR | | 90. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF CEATH BALITIMORE 3 Alfo 9c. COUNTY OF CEATH BALITIMORE COUNTY OF CEATH | | | | | | | | | | TIMORE | | |
| DIRECTOR | F | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | DAT TIMO | DU | 10c. CIT | Y, TOWN C | OR LOCATI | ON | | | | | | 10d, INSIDE CITY |
| 뜸 | ł | 106. CITY, TOWN OR LOCATION 106. CITY TOWN OR LOCATION 106. CITY TOWN OR LOCATION 107. INSIDE CITY LIMITS? 1 Uses 2 \(\text{N} \) NO | | | | | | | | | | | | |
| A. | I | 100. STREET AND NUMBER 240 B | LAKENEY | ROAD | | | 10f. | ZIP CODI | E | | | 10g. CIT | ZEN OF W | YHAT COUNTRY? |
| FUNERAL | | 333 Harden | La. | | | | | 12 | | | | 9 | 317 | b. USA |
| BY FUI | | 11. MARITAL STATUS 1 Never Married 2 Merried 1 YES, GIVE WAR OR OATES 13. WAS DECENDENT OF HISPANIC ORIGINATION ORIGINATION OF HISPANIC ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION ORIGINATION | | | | | | | n, Puerto I | | or No | 14. RACE Black Specia | - American Indian, t, White, atc. | |
| E G | I | 15. DECEOENT'S EOUCAT (Specify only highest grade con | ION mpleted) | | DECEDENT'S (Give kind of | work done | CCUPATIO | N I of workin | 70 | 16b | . KIND OF BUS | SINESS/INC | DUSTRY | |
| COMPLETED | Elementary/Secondery (0-12) College (1-4 or 5+) S+b CPADO PURCHASER CPLETO | | | | | | | | | | | | | |
| S P S | ŀ | 8th GRADe | | | THE | | WE TO | 19 MOT | HED'C NA | _ | STATION Middle, Maiden | | STOR | RE |
| | | Caiaphias Nunnall | v | | | | | | | Gave | | Surname) | | |
| 2 B | ľ | 19e. INFORMANT'S NAME (Type/Print) | 2 | | 19b. MAILIN | G ADORES | S (Street ar | | | | ber, City or Town | n, State, Zir | | |
| | | allen Clorein | | | 240. | RIG, | Kene | 4 1 | 9. | 2 | 301to. | Mg | 3.2 | 1228 |
| TSI I | | 20e. METHOO OF DISPOSITION 1 B Burtel 2 Cremetion 3 Remova | I Irom State | other | place) | | | | | | | CATION — | | |
| E | | 4 Donetion 5 Other (Specify) | SEE A A | _ [Wood] | lawn 1 | 7 | MAME AN | | | CILITY | l Ea | astor | . Md | / |
| examiner must be | | Dackie il. | Shar | mon | | H | IUBBA | RD F | UNEF | RAL H | IOME IN | | ore. | Md.21229 |
| medical | 1 | 23. PART (Enter the disesses, or comshock, or heart failure. Lis | | | | | | | | | | | | Approximate interval Between |
| 2 | | iMMEDIATE CAUSE (Finsi disease or condition resulting in death) | (V | retast. | 1 - 1 | dise | M | _ | | | | | | Onset and Deeth |
| even | | resulting in seattly | OUE TO | (OR AS A CONS | EOUENCE (| DF): | . ຄ | | 1 | | | | | |
| other traumatic event, | ł | Sequentially liet conditions, b | DUE TO | OR AS A CONS | SEQUENCE O | DE: | 1 15 | con | | | | | | |
| ry, or other traumatic CERTIFICATION | | if any, isading to immediate cause. Enter UNDERLYING | | Cerem | | ute | run | | | | | | | İ |
| E E | į | CAUSE (Diseese or injury that initiated events | DUE TO | (OR AS A CONS | SEOUENCE (| DF): | | | | | | | | |
| 2 0 | | resulting in desth) LAST | | | | | _ | | | | | | | |
| | | PART II. Other significant conditions of | contributing to | dssth but no | t resulting | In the u | ndarlying | ,causs | given in | Part I. | 24e. WAS AN | | 24b | . WERE AUTOPSY FINDINGS |
| DICAL | | Alchamer | 35 disc | est. | A | end | entre | 3 | | | PERFOR | | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| shows: | | | | | | | | | | | | | | 1 YES 2 NO |
| 23 s | | | | | | | | | | | | | | |
| PHYSICIAN: | | | OSPITAL: | | | OTHÉ | R: | | | eck only o | | | | |
| 14S | | 1 YES 2 NO 1 | 26e. DATE OF | | 3 L DOA | | 26c. INJ | | eeldenca | | SCRIBE HOW I | INJURY OC | CURED | |
| arked Y | ľ | 1 Natural 5 Pending | (Month, L | | II. | IJURY M | 1 🗆 Y | RK? ES 2 | □ NO | | | | | |
| IS MA | 100 | 3 Suicide 6 Could not be | 26s. PLACE (| OF INJURY — At, atc. (Specify) | home, ferm, | street, tec | tory, office | | | | CATION (Street or Town, Stete) | | r or Rural i | Route Number, |
| T Z8 | | 4 Homicide determined | | | | | | | | | | | | |
| ANT: If Item 2 COMPLET | | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: | | | | | | | | | | | | a) and manner as stated |
| S N | | 29b. SIGNATURE AND TITLE OF CERTIFIER | A | | Of three angul | ion, in my | opinion, d | | | | e and place, at | | | <u> </u> |
| IMPORTANT: If Item 28 is marked, or TO BE COMPLETED BY PHYS | - 11 | D >5a | K 19 | | | | | D | 175 | 37 | | • | Z. | (Month, Day, Year) |
| | | DARSHAW S. | | SE OF DEATH (I | 1/ | e, Print) | MT | Ro | yal | Am | , BA | LTO | 21 | 1217 |
| | | 31. DATE FILED (Month, Day, Year) | 32. REGISTR | AR'S SIGNATURI | E | | | | | | | | | |

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permit. Pages 1, 2, 3 should

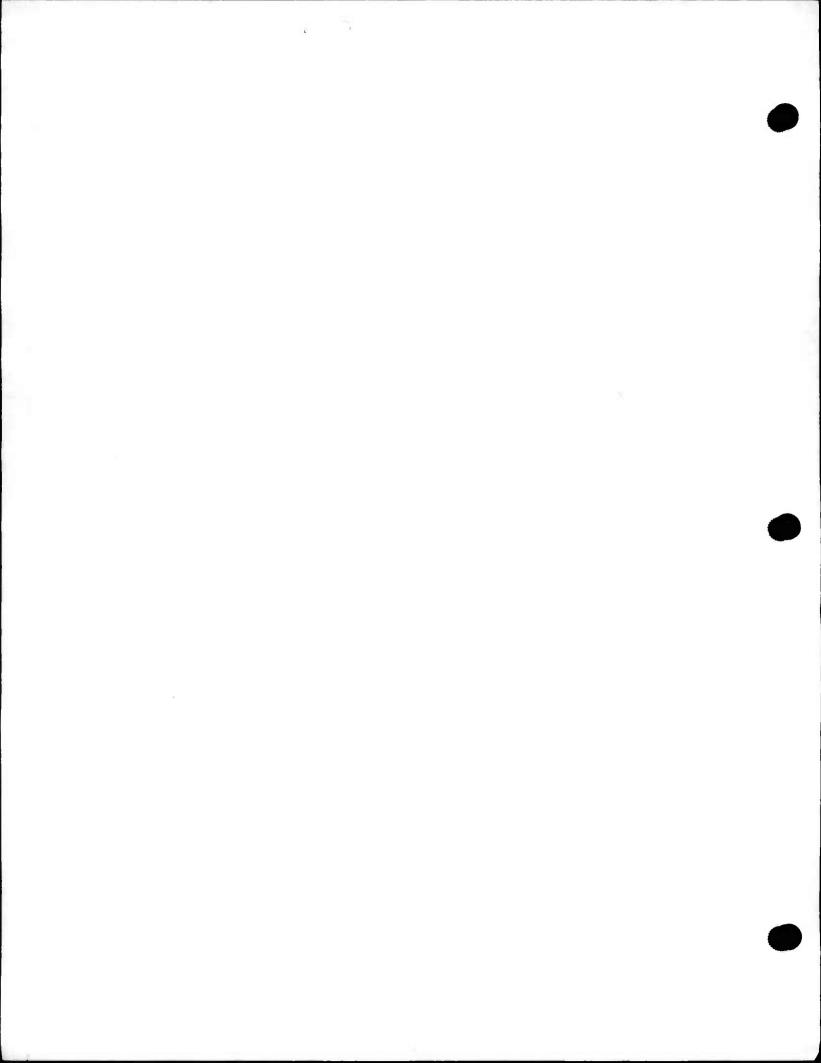
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| 0 | N | R. A | ar de | 60 |
| 15 | ATTE | 6 | s afte | 28 |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | S | DIRE | HOUR | Tem |
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| | SS | UNE | -thiu | ANT |
| | 포 | 一年 | w be | ORT |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified # once. |
| | | | | _ |

| | | | | | | | G | 0 34087 |
|---------------------|--|---|---|-----------------------------------|---|---|-----------------|---|
| | FOR 1 - STATE | STATE OF MARY | LAND / DEPARTI | | | | E | 0 0100. |
| | REGISTRAR | | CERTIFIC | AIE OF | DEALH | REG. NO | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | D | CHEN | 10:1 | | 2. DATE OF DEATH | 90 | EAR 3. TIME OF DEATH |
| | | | | | | | | 31 72 01M |
| | 4. SOCIAL SECURITY NUMBER | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8 | BIRTHPLACE (State or Foreign Country) |
| | 054 32 7933 | 1 🖳 M 2 🗆 F | 49 YRS. | JAN JAN J | HOURS WITH | 4-18-41 | | Maryland |
| | 9a. FACILITY NAME (If not institution, give a | treet and number) | 9 | b. CITY, TOWN O | R LOCATION OF DE | ATH | 9c. COUNT | Y OF DEATH |
| 5 | Harbor Hosp | oital | | Balti | more | | | |
| 5 l | RESIDENCE OF DECEDENT | | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. CITY, 1 | Baltí | | | | 10d. INSIDE CITY UMITS? 1 YES 2 NO |
| 4 | 10e. STREET AND NUMBER | | | 101. | ZIP CODE | | 10g. CITIZE | N OF WHAT COUNTRY? |
| FUNERAL | 1121 Wall Str | ceet | | | 21230 | | US | A |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EYE | | 13. WAS DECE | | IC ORIGIN? (Specify Yes | | I. RACE — American Indian, Black, White, atc. |
| | 1 Never Married 2 Married | FORCES? 1 Y | | | cify Cuban, Maxican 2 NO Specify | n, Puerto Rican, atc.) | | Black, White, atc. Specify: |
| B | 3 Wildowed 4 Divorced | 1 120, 0172 1811 01 | T DATE OF | , , , , , | 2 III NO Opeany | | | Black |
| | 15. DECEDENT'S EDU | | 18a. DECEDENT'S US | UAL OCCUPATIO | N | 16b. KINO OF BU | SINESS/INDUS | STRY |
| ᇤ | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of wor life. Do NOT use i | k done during mos retired.) | at of working | | | |
| 7 | | 0011090 (1 4 01 0 1) | Lub | orer | | ŀ | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | ME (First, Middle, Maiden | Surname) | |
| Ö | CHANNET. | | | | BLANCI | The same of the same | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | | 19h MAILING A | DDRESS (Street or | | Soute Number, City or Tow | n State 7in C | odel |
| 2 | Harbor Hsp/Med | d Pocorda | | more, M | | iodio Nambol, Ony or lon | n, otato, zip o | 000) |
| | 20a, METHOD OF DISPOSITION | | 20b. PLACE OF DISPOSIT | | | T 00- 15 | OATION OF | La Taura Chata |
| | 1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | noval from Stata | other place) | | | | | y or Town, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | Ronald | Wade, Di | 22. NAME AN | D ADDRESS OF FA | STATE | ANAT | OMY BOARD |
| | Marales | 1111 120 | 7 | | | | | ,MD 21201 |
| 575 | 7 900000 | 1500m | | | | | | |
| | 23. PART i. Entar the diseasas, or ahock, or haart failure. | List only one cause of | n aach Ilna. | | | n ae cardiac or reap | iretory erre | et, Approximata interval Between |
| | IMMEDIATE CAUSE (Finel | 11 | 1 | - 0 | - | | | Onset and Daeth |
| | disease or condition resulting in death) | . Hel | patic t | ou lux | e. | | | |
| | | DUE TO (OR | patie # us a consequence of: ul Fail | 1 | | | | |
| Z | A CONTRACTOR NOT THE PARTY OF T | . Kei | ral tail | cure- | | | | |
| 음 | Sequantially list conditions, if any, leading to immediate | (| | | | | | |
| S | CAUSE (Disease or injury | 20 | p.sis | | | | | |
| 드 | that initiated events | DUE TO (OR A | A CONSEQUENCE OF): | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | |
| 2 | DARW II ON THE INTERNAL TO THE | - | | | | | | |
| ¥ | PART ii. Other eignificent condition | a contributing to deat | n but not resulting in | the undariying | g cause given in | PERFQ | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 8 | | | | | | 1 YES | 2 NO | COMPLETION OF CAUSE DF DEATH? |
| 9 | | | | | | | | 1 TYES 2 NO |
| = | | | | | | | | |
| | | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | |
| Ϋ́ | 25. WAS CASE REFERRED TO MEDICAL | | | OTHER: | e 5 🗆 Realdence | 8 Other (Specify) | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | Outpatient 3 🗆 DOA 4 | | | | DI HIRV OCCI | |
| HYSICIA | EXAMINER? | 1 Inpatient 2 ER/ | RY 28b. TIME | OF 28c. INJ | URY AT | 28d. DEŞCRIBE HOW | INJUNT OCCU | IRED |
| Y PHYSICIAN: MEDICA | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inputlant 2 ER/ | RY 28b. TIME | OF 28c. INJ RY WO M 1 \[\] | RK? | 28d. DEŞCRIBE HOW | INJUNY OCCU | IRED |
| B | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28a. DATE OF INJU 28a. DATE OF INJU (Month, Day, Ye) 28a. PLACE OF INJ | RY 28b. TIME INJUI | M 1 D | PIK? YES 2 NO | 281. LOCATION (Street | and Number of | |
| B | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF INJU (Month, Day, Ye | RY 28b. TIME INJUI | M 1 D | PIK? YES 2 NO | | and Number of | |
| B | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 8 Could not be datermined | 1 Inpatient 2 ER/4 28a. DATE OF INJU (Month, Day, 16) 28e. PLACE OF INJ building, atc. (| RY 28b. TIME INJUI | M 1 Y | PK? YES 2 NO | 281. LOCATION (Street City or Town, State | and Number o | r Rural Route Number, |
| B | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only) ERTIFYING PHYS | 28a. DATE OF INJU (Month, Day, Ye. 28a. PLACE OF INJ building, atc. (| RY 28b. TIME INJUI | M 1 N | PK? /ES 2 NO | 281. LOCATION (Street City or Town, State to the cause(a) and ma | and Number o | r Rural Route Number, |
| B | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only) ERTIFYING PHYS | 28a. DATE OF INJU (Month, Day, Ye. 28a. PLACE OF INJ building, atc. (| RY 28b. TIME INJUI | M 1 N | PK? /ES 2 NO | 281. LOCATION (Street City or Town, State to the cause(a) and ma | and Number o | r Rural Route Number, |
| E COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only) ERTIFYING PHYS | 28a. DATE OF INJU (Month, Dey, Ye. 28a. PLACE OF INJ building, atc. (BICIAN: To the best of my k ER: On the basis of axemin | RY 28b. TIME INJUI | M 1 N | PK? /ES 2 NO | 28f. LOCATION (Street City or Town, State to the cause(a) and me time, data and place, a | and Number of | f Rural Route Number, 5. cause(a) and manner as stated. SIGNEO (Month, Day, Year) |
| COMPLETED BY | EXAMINER? 1 VES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be datermined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINI | 28a. DATE OF INJU (Month, Dey, Ye. 28a. PLACE OF INJ building, atc. (BICIAN: To the best of my k ER: On the basis of axemin | RY 28b. TIME INJUI | M 1 N | PK? ZES 2 NO a and plecs, and dus esth occured at the | 28f. LOCATION (Street City or Town, State to the cause(a) and me time, data and place, a | and Number of | r Rural Route Number, 5. cause(a) and manner as stated. |

52. REMISTRAR'S SIGNATURE

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31. DADELET 1.3/1990



TO THE HOSPITAL OF VIENCIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR. Jet this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after call with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| OF DEATH | | | | | | |
| tate or Foreign | | | | | | |
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| IDE CITY ITS? | | | | | | |
| INTRY? | | | | | | |
| ican Indian, itc. | | | | | | |
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| land | | | | | | |
| 21087 | | | | | | |
| pproximata tarval Between naet and Death | | | | | | |
| Sequantially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| JTOPSY FINDINGS LE PRIOR TO TION DF CAUSE 'H? S 2 NO | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO. 1 Inpetient 2 ER/Outpetient 3 DOA 4 Alursing Home 5 Residence 8 Other (Specify) | | | | | | |
| | | | | | | |
| nber, | | | | | | |
| nner as stated. | | | | | | |
| (42) | | | | | | |
| TH S | | | | | | |

DO THE WORK OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE ha Davidson Randale

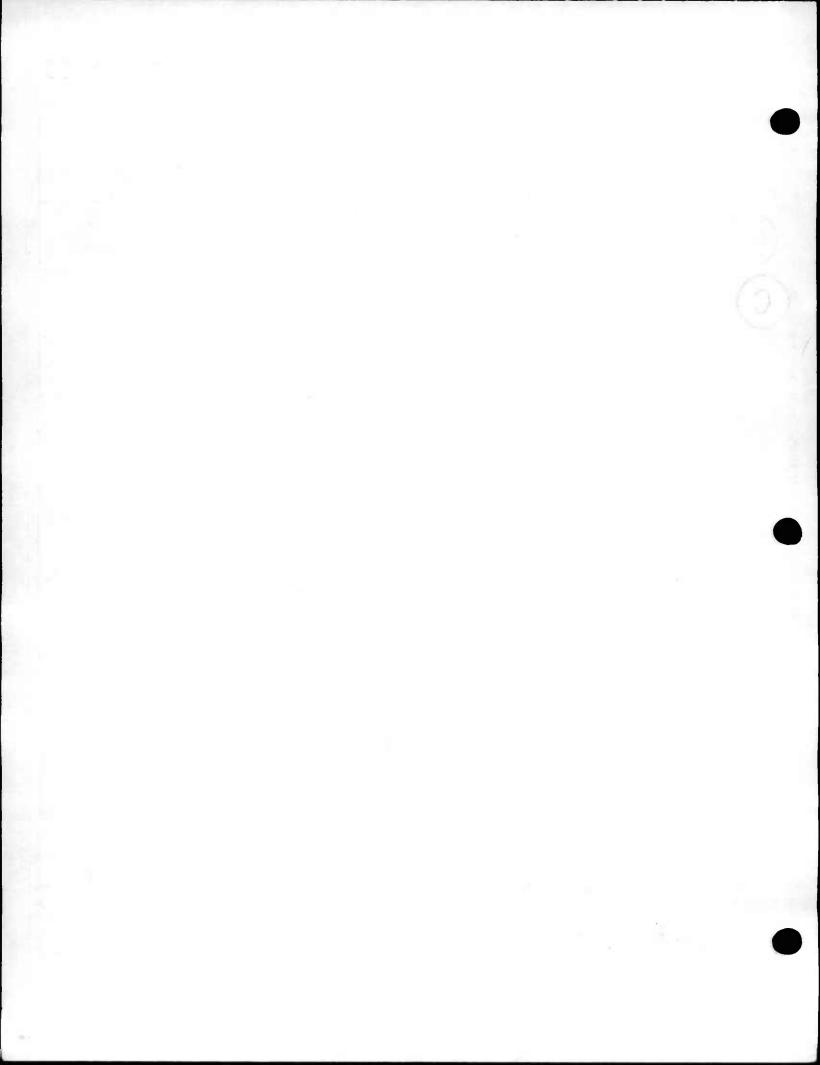
th, Day, Year) 2 1990

31. DATE FILED (Mont

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| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND ME | NTAL HYGIENE |
|---|---|--------------|
| R | CERTIFICATE OF DEATH | REG. NO. |
| | | |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | 0 0,000 |
|----------------------------------|--|---|--|---------------------|--|---|---|--|
| 177 | 1. DECEDENT'S NAME (First, Middle, Last) | Fresen | | | | 2. DATE OF DEATH MONTH D | Y Q YEA | |
| FUNERAL OFFICTOR | 4. SOCIAL SECURITY NUMBER 524 58 9200 | 5. SEX 1 M 2 D F 6. AGE (Ir | YRS. MONT | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 6. BI | RTHPLACE (State or Foreign nuntry) Conn |
| | 9a. FACILITY NAME (If not institution, give at MCI) DIAN CIOME | . 13 | АТН | imore Co | | | | |
| | 10a. STATE 10b. COUNTY | altimore Co | | TOWS | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | 10f. ZIP CODE | | | | | 10g. CITIZEN C | OF WHAT COUNTRY? |
| UNE | 328 Stevenso | 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HI | | | | | ACE — American Indian, Back, White, alc. | |
| B | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 ☐ YES 2 ☐ NO If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S USU/ (Give kind of work of life. Do NOT use reti | lone during mo | | 16b. KIND OF BU | SINESS/INDUSTR | Y |
| MO | 17. FATHER'S NAME (First, Middle, Lest) | 12 1 0 | | | 16. MOTHER'S NA | ME (First, Middle, Malden | Sumame) | |
| BE | JOHN FRESE | N | | | | HANSEN | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | ECEN Wise | | | | Route Number, City or Tow | | |
| | ISABEL S. FR 20e. METHOD OF DISPOSITION 1 □ Burlel 2 □ Cremetton 3 □ Remit 45€ Donation 6 □ Other (Specify) | 20b. | PLACE OF DISPOSITION other place) | | | ,Balto., | CATION — City of | |
| | 21. SIGNATURE OF PUNERAL SERVICE LIC | Ronald V | Wade, Dir | | ADDRESS OF FA | o St.,Ba | | MY BOARD 21201 |
| PHYSICIAN: MEDICAL CERTIFICATION | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reepiretory errest, shock, or haert failure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| | PART II. Other significant condition | a contributing to death bu | it not reaulting in th | a undarlying | cause given in | Part i. 24a. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS MANLABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | |
| VSIC | 1 U YES 2 NO | HOSPITAL: 1 Inpetient 2 ER/Outpe | | HER: Nursing Hom | 5 🗆 Residence | 6 Other (Specify) | | |
| ву РН | 27. MANNER OF DEATH 1 Netural 6 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 NO | | | | 28d. OEŞCRIBE HOW | INJURY OCCURE | 0 |
| | 3 Suicide 8 Could not be 4 Homicide determined | Al home, farm, street | | | 261. LOCATION (Street City or Town, State | ION (Street and Number or Rural Route Number, Town, State) | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. | | | | | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | h MP. | | | 29c. LICENSE NUI | | 1 Dec | NEO (Month, Day, Year) -9 1980 |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (18/10). PANDEL O'MANSKY BYOTA LOCH RAVEN BLVD BALTO. 2/209 | | | | | | | |
| | DECI (Month, Day, Year) | 32. REGISTRAR'S SIGN | THRE | | | | | |



| 314 | fing phy the bu | ВУ | Widowed 4 Divorced | IF YES, GIVE WA |
|---------------------|--|-------------------------------------|--|------------------------------|
| ဗ္ဗ | attendi | 8 | 15. DECEDENT'S EDUC (Specify only highest grade of | |
| 212 | the hospital or attr detached for use once. | PLET | Elementary/Secondary (0-12) | College (1-4 or 5+) |
| MAHYLAND 21203-3146 | retained by the hospital or attending 5 should be detached for use as the notified at once. | TO BE COMPLETED | 17. FATHER'S NAME (First, Middle, Last) 10s. INFOSSIGNAT'S NAME (TyposPrint) | Doper |
| HE M | 6 ney be re you age 5 | F | 20a METHOD OF DISPOSITION 1 Donation 2 | Liteon |
| BALA | ter dam. Page the transfer of wal. | | 21. SHOMATURE OF FUNERAL DESKICE SHO | D M |
| 40 | in by reme | | 23. PART i. Enter the diseasee, or c ahock, or heart fallure. I | |
| 'n, | uted within 24 nours after completely filled in by the rial, cremation, or removal c event, the medical | | IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | . Gastro |
| BOX 13146, | con ial, | ATION | Sequentially list conditions, if eny, leading to immediate ceues. Enter UNDERLYING | Dissem DUE TO (Fulmin |
| д. О | PHYSICIAN: The law requires that the death certificate be executhis certificate has been signed by the attending physician and with the State Dept, of Health and Mental Hygiene prior to burinked, or Item 23 shows any injury, or other traumatit | BY PHYSICIAN: MEDICAL CERTIFICATION | CAUSE (Disease or injury that initieted events recuiting in deeth) LAST | DUE TO ((|
| RECORDS, | s that the dea ned by the att lith and Menta any injury, | DICAL | PART II. Other eignificent conditions | contributing to |
| | law requires as been sign bept, of Hea 23 shows | N: ME | | |
| VITAL | CIAN: The striffcate has be state to the sta | /SICI/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO | HOSPITAL: |
| | NG PHYSICI fter this cer eath with th | у РН | 27. MANNER OF DEATH 1 X Netural 5 X Pending 2 Accident Investigation | 28e. DATE OF I (Month, Da |
| DIVISION OF | ATTENDING CTOR: Afte after deat 28 Is m | TED B | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF building, a |
| 2 | HOSPITAL OR ATTENDING PHYSICIAN: The law requires th FINERAL DIRECTOR: After this certificate has been signed within 72 hours after death with the State Dept. of Health TANT: If Hem 28 Is marked, or Hem 23 shows an | BE COMPLETED | 29e. CERTIFIER 1 💢 CERTIFYING PHYSIC one) 2 🗌 MEDICAL EXAMINE | CIAN: To the best of ax |
| | TO THE HOSPIT TO THE FUNER De filed within 7 | TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 2 Glick |
| | | F | 30. NAME AND ADDRESS OF PERSON WHO | |
| | | | WILLIAM J. HICK | EN, M.D., |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | |
|------------------|--|---|--|---|---|----------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Africolin, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| 1 1 | TYREECE, RENEE, | FREEMAN | | - 1 | MONTH 12 | 10 90 | 15:22 w | | |
| | | S. SEX S. AGE (In yes, lest to | YHS. WOTHER SAME | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, War) 10/16/90 | 12 | METODO 2/1 | | |
| DIRECTOR | BE FACILITY NAME OF DECEDENT (TOWN OF DEATH) SE. COUNTY OF DEATH | | | | | | | | |
| | 10a. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCA | L ZIP COOK | 5 m | rd. | 104. INSIDE CITY LIMITS? 1 YES 2 NO WHAT COUNTINY? | | |
| FUNERAL | 900 Osto | 12. WAS DECEDENT EVER IN U.S. ARM | Betten | 2 96 | 229 C ORIGINY (Specify Yes | U | S A | | |
| B | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES 2 NO | If yea, as | pecify Cuban, Mexican 3 2 1 MO Specify | , Puerto Rican, etc.) | S | Sloal | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementary/Secondary (0-12) | ompleted) (Give | EDENT'S USUAL OCCUPATI e kind of work done during m Do NOT use retired.) | ON ost of working | 18b. KIND OF BUS | INESS/INDUSTR | γ | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) | Incemor | | 18. MOTHER'S NAM | AE (First, Middle, Malden | Surname) | laken | | |
| 2 | 10s. INFORMANT'S NAME (Typostrint) | Ireamon : | MAILING AODRESS (Street | uf A | dute Number, City or Text | The, | Ama | | |
| | 20a METHOD OF DISPOSITION 1 Description March Mar | other place | Dunk | ount | Sol B | ation - OB o | Town, State | | |
| | > If lethis | Milimo | 2 230 | Dates of Fac | Kyth | les! | BASIA | | |
| | 23. PART i. Enter the diseasee, or co ahock, or heart fallure. L | implications that coused the dealist only one cause on each line. | ith. Do not enter the me | ode of dying, euch | es cerdiec or reepi | retory erreet, | Approximate Interval Between | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | Gastrointesti | nal bleeding | 3 | | | Onset end Deeth | | |
| NOL | Sequentially list conditions, If eny, leading to immediate Disseminated intravascular coagulation DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CA | ceuee. Enter UNDERLYING CAUSE (Disease or injury | Fulminant seps | | ive organ | ism pendin | ıg | | | |
| CERTIFICATION | that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CAL | PART II. Other eignificent conditions | contributing to death but not re | aulting in the underlying | ng ceuee given in | Pert I. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| PHYSICIAN: MEDIC | | | | | 1\(\frac{1}{12}\) YES 2 | | COMPLETION OF CAUSE OF DEATH? 1\(\sum_1 \) YES 2 \(\sum_1 \) NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 28. F | PLACE OF DEATH (Che | ack only one) | | | | |
| SIC | EXAMINER? | HOSPITAL: 1X inpatient 2 ER/Outpatient 3 | OTHER: | me 5 🗆 Realdenca | 8 Other (Specify) | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 X Natural 5 X Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | M 1 _ | JURY AT ORK? YES 2 NO | 28d. DEŞCRIBE HÓW I | NJURY OCCURE | D | | |
| | 3 Suicide 8 Could not be determined 28. Could not be determined 28. PLACE OF INJURY — Al home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 💢 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as atted. 2 🗆 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, date and place, and due to the cause(a) and manner as atted. | | | | | | | | |
| TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | Hickory V | n.D. | 29c. LICENSE NUN D04964 | IBER | | NED (Morith, Day, Year) | | |
| - | 30. NAME AND ADDRESS OF PERSON WHO | N. M.D., St. Agr | | l, 900 Ca | ton Ave., | Baltimo | ore 21229 | | |
| | 31. DATE FILED (Morith, Day, Year) 32. REGISTRAR'S SIGNATURE DEC 1 2 1990 Fulia Savidon Pandalle | | | | | | | | |

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filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should

notified at once. 踞

pe must

23 shows any injury, or other traumatic event, the medical examiner

cremation, or removal.

or Item

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TO THE FUNERAL UNICOUST after death with the selection within 72 hours after death with the selection within 72 hours after death of IMPORTANT: If Item 28 is marked, or

뿔 2 1 YES 2 NO

5 Pending Investigation

6 Could not be

determined

27. MANNER OF DEATH

Natural

2 Accident

3 Suicide

29a. CERTIFIER

4 Homicide

(Check only one)

29b. SIGNATURE AND TITLE OF CERTIFIER

INIV. OF MO

DEC

31. DATE FILED (Month, Day,

FUNERAL

| | OR ATTENDING PHYSICIAN: The law requires "Again Seath pertificate be executed within | etely | emati | |
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | M P | dmo | I, Cre | |
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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last, 12 AMUEL ALLOWAY 4. SOCIAL SECURITY NUMBER S. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH (Month, Day, Year IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 Hope 2 DF 9a. FACILITY NAME (II) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY O 5720 DIRECTOR RESIDENCE OF DECEDENT 10e. STREET AND 10g. CITIZEN OF WHAT COUNTRY? 2122 WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-AR OR DATES 1 Never Married 2 Married If yes, specify Cubar, Maxican, Puerto Rican, etc.) YES 2 TO NO Specify βÁ 3 Widowed 4 Divorced COMPLETED IS. DECEDENT'S EDUCATION MENT'S USUAL OCCUPATION and of work done during most ge (1-4 or 5+) 2 0.0 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or reepiratory arrest, ahock, or heart failure. List only ona ceuse on each line. IMMEDIATE CAUSE (Final disease or condition RESPIRATORY AND
DUE TO (OR AS A CONSEQUENCE OF): CARDIAC reaulting in death) HEPATOCELLUI PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one)

HOSPITAL:

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

26a. DATE OF INJURY (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

tlent 2 - ER/Outpetlent 3 - DOA

26s. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify)

28b. TIME OF

S. GREENE

28c. INJURY AT WORK?

1 YES 2 NO

29c. LICENSE NUMBER

Approximate Interval Between Onset and Daeth IMMEDIA ARCINOMA 6 MONTHS 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 | YES 2 NO 1 YES 2 NO OTHER:
4 □ Nursing Home 5 Residence 6 □ Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated. 29d. DATE SIGNED (Month, Day, Year) 2120 DHMH-18 Rev 1/89

34091

10d. INSIDE CITY LIMITS? 1 YES 2 110

American Indian,
 White, atp.

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14. RACE

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for use as the

page 5 should be

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CERTIFICATION

PHYSICIAN: MEDICAL

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| DIVISION OF VITAL RECORDS, F.O. BOA 13148, | SSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 noun | INERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in | thin 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or r |
| | AL | AL | 2 |
| | P | ER | E |
| | 83 | 2 | 45 |

| | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | SIAIE UF M | ARYLAND / DEP/ CERTI | FICAT | | | | REG. N | | | 2 7045 | OF DEAT | |
|---|--|---|--|---|----------------|-------------------|-----------------|-------------------------------------|---|-------------|--------|----------|-----|
| | Vivian L. G | reen | | | | | | December | DAY | YEAR 990 | | : 40 | |
| | 4. SOCIAL SECURITY NUMBER 216-24-5333 | 5. SEX | 6. AGE (In yrs. last birthda 65 YRS | MONTHS | DAYS | IF UNDER HOURS | 24 HRS. MIN. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Fo. | | | reign | |
| HOL | 9a. FACILITY NAME (If not institution, give: Maryland Gener RESIDENCE OF DECEDENT | - | | more | | | 9c. CO | JNTY OF D | DEATH | | | | |
| DIME | M D | Υ | | CITY, TOWN ALTIN | | | ΙΤΥ | | | | JLIN | HDE CITY | |
| EHAL | 1806 N. GUIL | 10 | 2 1 | 202 | | 10g. Cl | USA | | | | | | |
| BT FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | TEVER IN U.S. ARMED YES 2 NO AR OR DATES | ES 2 100 If yes, specify Cuban, Mexican | | | | | n, Puerto Ricen, etc.) Black, White, etc. | | | | |
| APLEIEU | 15. DECEOENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 11th | | (Give kind life, Do NO | ECCOENT'S USUAL OCCUPATION live kind of work done during most of working ANNING FACTORY | | | | | | OUSTRY | | | |
| E COM | 17. FATHER'S NAME (First, Middle, Last) EDDIE WALKER | | | | | 100 | | ME (First, Middle, Maid LEE GRAN | | | | | |
| 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1806 GUILFORD AVE BALTIMORE, MD. 21202 | | | | | | | | | 202 | | | | |
| | 20s. METHOD OF DISPOSITION X X Burlel 2 Cremation 3 Ren 4 Donation 5 Other (Specify) | POSITION (A | ame of ce | metery, crem | natory or Y | | L T I M | | | | | | |
| | 21. SIGNATURE OF FUNERAL SETTINGE LI | Paret | 0 | WI | И.С. | | RCH | F.H. 11 | | | OR TH | ΑV | Ε. |
| | 23. PART L Enter the diseesas, or | complications that | caused the death. D | o not ente | r the mo | oda of dy | ing, suc | ch aa cardiac or re | piratory a | rreat, | A | pproxim | ste |

PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dilated common bile duct

Pleural effusion

Acute Tracheobrochitis

25. Was CASE REFERREO TO MEDICAL EXAMINER?

HOSPITAL:

| Dipatient 2 | ER/Outpettent 3 | DOA | 4 | Nursing Home 5 | Residence 6 | Other (Specific)

1 | YES 2 | NO inpetient 2 - ER/Outpetient 3 - DOA me 5 - Residence 6 - Other (Specify) 4 Nursing He 27. MANNER OF DEATH 28s. OATE OF INJURY (Month, Day, Year) 26c, INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 5 Pending 1- Netural
2 Accident
3 Suicide 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide

29s. CERTIFIER
(Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Clinical Heptic Encephalopathy

Carcinoma of Common Bile Duct

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

DUE TO (OR AS A CONSEQUENCE OF):

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Thomas Williamson C/O Maryland General Hospital 827 Linden Ave.

DEC 1 2 1990

IMMEDIATE CAUSE (Final

Sequentially list conditions,

if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury

that initiated events

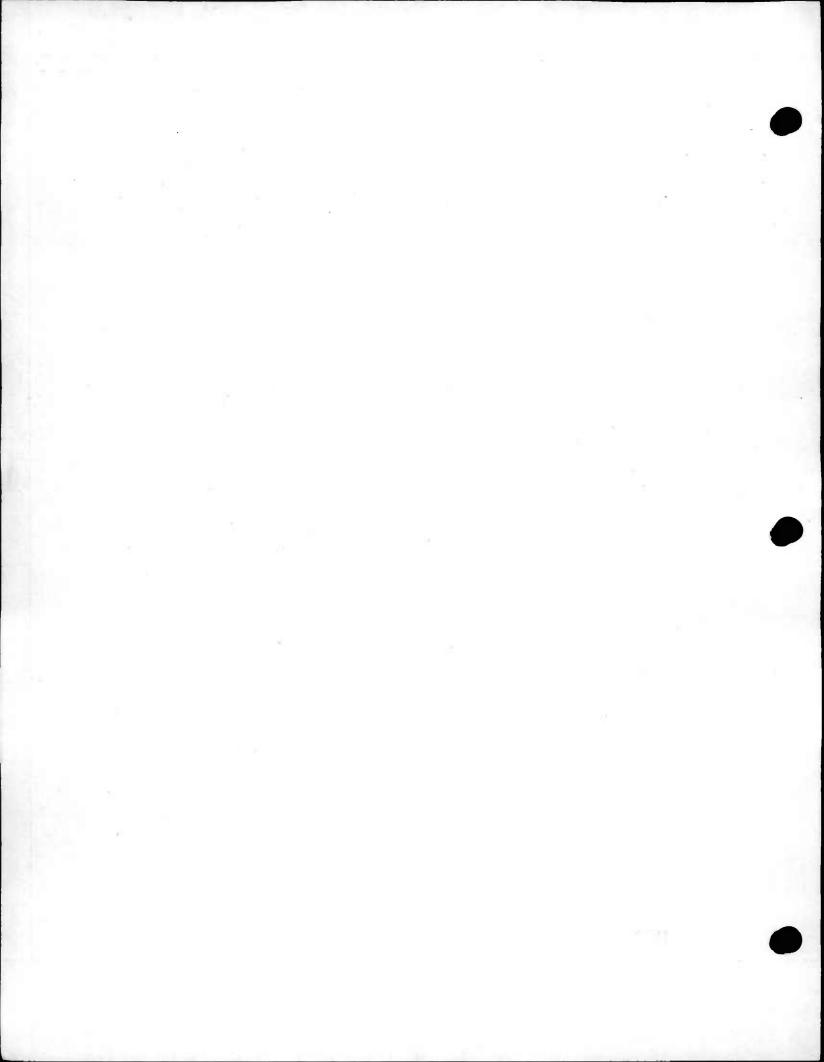
resulting in death) LAST

disease or condition resulting in death)



▶ 12-08-90

Onset and Death



DHMH-16 Rev 1/89

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| BALLIMORE, MARYLAND 21203-3146 the results of the possible of attention obvision. | tor, page 5 should be detached for use as the burial-transit permit. Pages 1 | rust be notified at once. |
|--|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALLIMOHE, MARYLAND 21203-3146 is uncomed to previous the previous that the death certificate he executed within 24 hours after death. Page 6 may be retained by the broatist or attending physician. | E FUNE CHECKET Are this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should awriting from the State has been signed by the attending burial, cremation, or removal. | HETANT. If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | SIAIE UF MARY | | | | DEATI | | ENIAL HYGIE REG. N | | | | |
|-------------------|---|---|-------------------------------|----------------|--------------|--|-----------|---|-------------|----------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | - Cni | ULN | | | | | 2. DATE OF DEATH | DAY) | JEAN ! | 3. TIME OF DEATH | |
| | | | E (In yrs. lest birthde |) IF UNDE | R 1 YEAR | IF UNDER 24 | L HRS. | 7. DATE OF BIRTH | 7 | 6. BIRTH | M IPLACE (State or Foreign | |
| | 2181863601 | □ M 2 Ø F 6 | 7 YRS | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) 12–18– | 22 | Countr | n) arvland | |
| ~ | 9a. FACILITY NAME (If not institution, give street Good Samaritan Hos | The second second | | | | R LOCATION | OF DEAT | гн | 9c. CO | UNTY OF D | EATH | |
| Ĕ | RESIDENCE OF DECEDENT | brear | | Baltimore | | | | | | | | |
| DIRECTOR | 100. STATE 10b. COUNTY Maryland Balti | more | 10c. C | ITY, TOWN | | on y Hal | 1 | | | | 10d. INSIDE CITY LIMITS? | |
| | 100. STREET AND NUMBER | more | | | | ZIP CODE | | | 10g. C | ITIZEN OF V | 1 YES 2 NO | |
| FUNERAL | 4103 Slater Avenue | | | | | 21 | 236 | | | USA | | |
| BY | 11. MARITAL STATUS 12 1 Never Married 2 Married 3 N Wildowed 4 Divorced | WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | S 2 NO | 13. | If yee, sp | ecify_Cuban, | | ORIGIN? (Specify Puerto Ricen, etc.) | Yae or No— | 14. RACE Bleck Speci | E — American Indian, k, White, etc. White | |
| | 15. DECEDENT'S EDUCATI (Specify only highest grade com | npleted) | 16a. DECEDENT | 'S USUAL C | during mo | ON at of working | | 16b, KIND OF I | BUSINESS/II | NDUSTRY | | |
| <u> </u> | Elamentary/Secondary (0-12) C 12th grade | College (1-4 or 5+) | Cleric | | | | | Leve | r Bro | ther | s | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 21 | | | | | | E (First, Middle, Malo | | | | |
| H | Archibald Robert A | rken | 19b. MARLI | NG ADDRES | S (Street s | | | Ella Har | | | | |
| 입 | Mr. Michael Gould | | | | | | | altimore | | | d 21236 | |
| | 20e. METHOD OF DISPOSITION 1.30 Burial 2 Cremation 3 Removal 4 Donetion 5 Other (Specify) | I from Stata | other place) | Parkw | ood | Cemet | ery | 20c. LOCATION — City or Town, State Baltimore, Maryland | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS AUGUST 24. | | Ham E | | Lass | | uner | un al Home d. Balto | 200 | . O | 1236 | |
| | 23. PART i. Enter the diseases, pr cpm ahock, or heert failure. Liat | | | | | | | | | | Approximate Interval Between | |
| | IMMEDIATE CAUSE (Final | | | C 11 | | | | | | | Onset and Death | |
| | reauiting in death) a | DUE TO (OR AS | A CONSEQUENCE | OF): | >CK | in the same of the | | · | | | 24.425 | |
| Z | Sequentielly list conditions, b | LLL | PMEL | MOME | 114 | | | | | | 7, | |
| CERTIFICATION | if eny, leeding to immediate ceuse. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | | |
| [] | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | | | | | |
| ER | reaulting in deeth) LAST | | | | | | | | | | | |
| DICAL | PART II. Other aignificant conditions c | | | - | - | g ceuse giv | ven in P | | AN AUTOPS | Y 24b | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| | RHEUMATO | BNA ASION | RTHR | 1.17 | | | | 1 _ YES | 2 NO | | COMPLETION OF CAUSE DF DEATH? | |
| 2 | 2 HEVMA | 53-4 | SAAT | 100 | SI | A8 = | | _ | | | 1 TYES 2 NO | |
| CIA | | OSPITAL: | | OTHE | | ACE OF DE | ATH (Chec | k only one) | | | | |
| HYS | 1 ☐ YES 2 ☑ NO 11 | 28a. DATE OF INJUR | Y 28b. | 4 □ Nu | rsing Hon | IURY AT | | Other (Specity) 26d. DESCRIBE HD | W INJURY C | OCCURED | | |
| BY PHYSICIAN: MEI | 1 M Natural 5 Pending 2 Accident Investigation | (Month, Day, Year |) | INJURY M | WC | YES 2 | | • | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, etc. (S) | RY — At home, ferr pecify) | n, street, fac | ctory, offic | • | | 281. LOCATION (Stre City or Town, Str | | ber or Rural | Route Number, | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C | | | | | | | | | | e) and manner ea stated. | |
| B | 29b. SIGNATURE AND TITLE OF CERTIFIER | a Se | 4 | | | 29c. LICEN | ISE NUME | BER | 29d. D | ATE SIGNED | Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF | DEATH (ITEM 27) (7) | rpe, Print) | 16 | TOOD HOOT | 80A | MARITH EN'B | LVI | M | 121239 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SI | | 0 | مبرم | vidson | D. 1. | .00 | | la: | | |
| | 14/1/9 | ULU | 1 / 1330 | | بالله يها | 1/400/~ | Mandone | Julio . | | | | |

Pages 1, 2, 3 should

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| O. BO | certificate |
| 7 | death |
| S | the |
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| | requires |
| | 36 |
| ⋖ | The |
| VISION OF VITAL RECORDS, P.O. BOX 13146 | ATTENDING PHYSICIAN: The law requires that the death certificate be executed within |
| 20 | SNIONS |
| 2 | ATT |
| | |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. OECEOENT'S NAME (First Middle Last) 2. DATE OF DEATH MONTH 110 JOSEPH WALTER GRANGER, JR. 90 P 12 4. SOCIAL SECURITY NUMBER 6. SEX 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH DAYS HOURS MIN. 1 3 M 2 - F 215-10-4287 YRS. 23,1908 Baltimore 9a. FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore Baltimore Summit Nursing HOme RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY LIMITS? Baltimore Md 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 1043 Cooks Lane 21229 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yea, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 N NO Specify: 14. RACE --- American Indian, Black, White, etc. 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5+) 10th grade Western Electric Supervisior 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Malden Surnan Joseph W. Granger, Sr. Lillie May Fleishell 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 10197 Green Clover Dr., Ellicott City, Md 21043 Patricia Boyer 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or 20c. LOCATION - City or Town, State Loudon Park Cemetery BAltimore | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY
Hubbard Funeral Home Inc. 4107 Wilkens Avenue, BAltimore, Md 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each lins. Approximate IMMEDIATE CAUSE (Final Onset and Death disease or condition_ At cute resulting in death) meumo DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, isading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury OUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 - YES 2 11-NO OF DEATH? 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO HOSPITAL:
1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA | 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 84 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY --- At home, farm, street, factory, office building, stc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

(Chart pol)

(CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. ation and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the besis of ax 29b. SIGNATURE AND TITLE OF CERTIFIER 20c LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) B ames E our 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J.E. ROWE Nursen

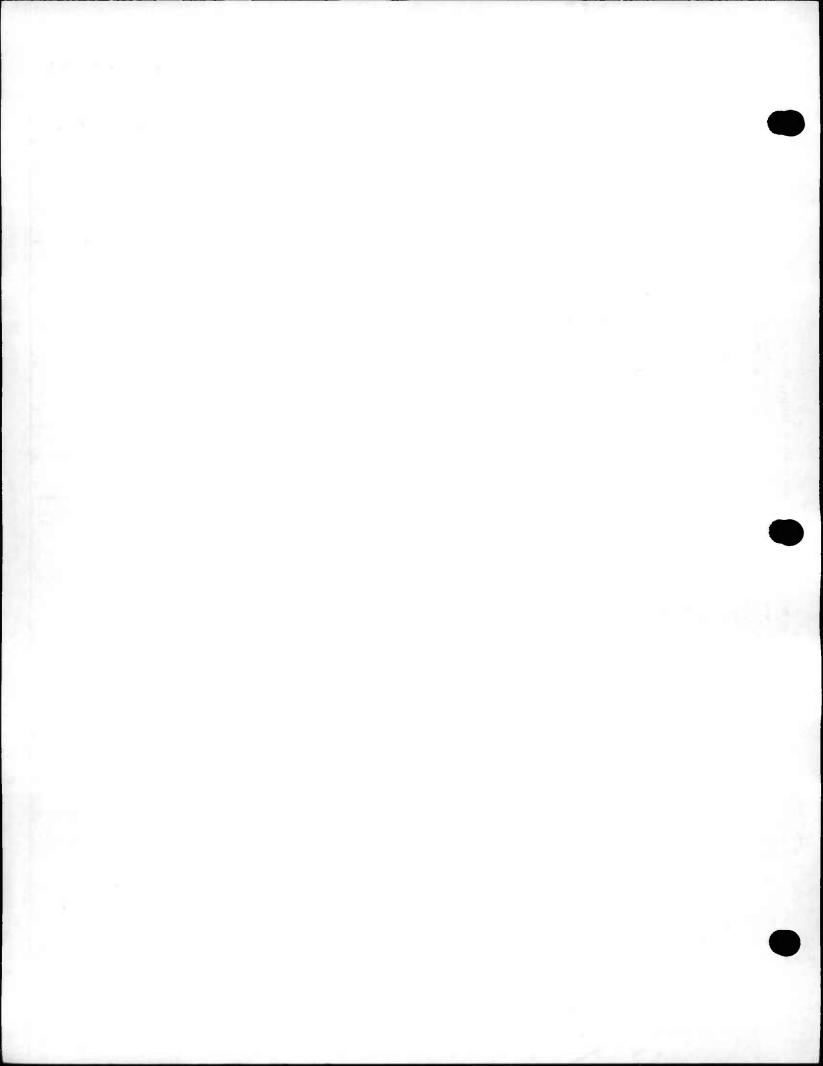
HoroLE

32. REGISTRAR'S SIGNATURE

Savidson Randelle

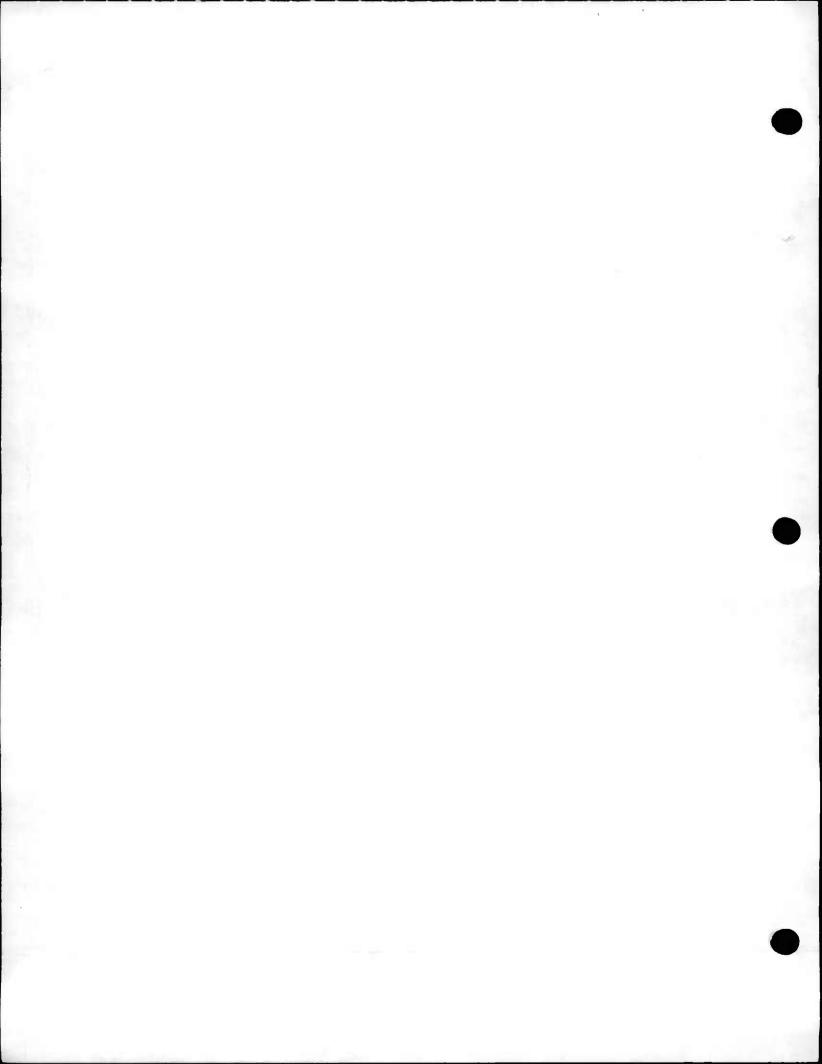
31. DATE FILED (Month, Day, Year)

1990



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

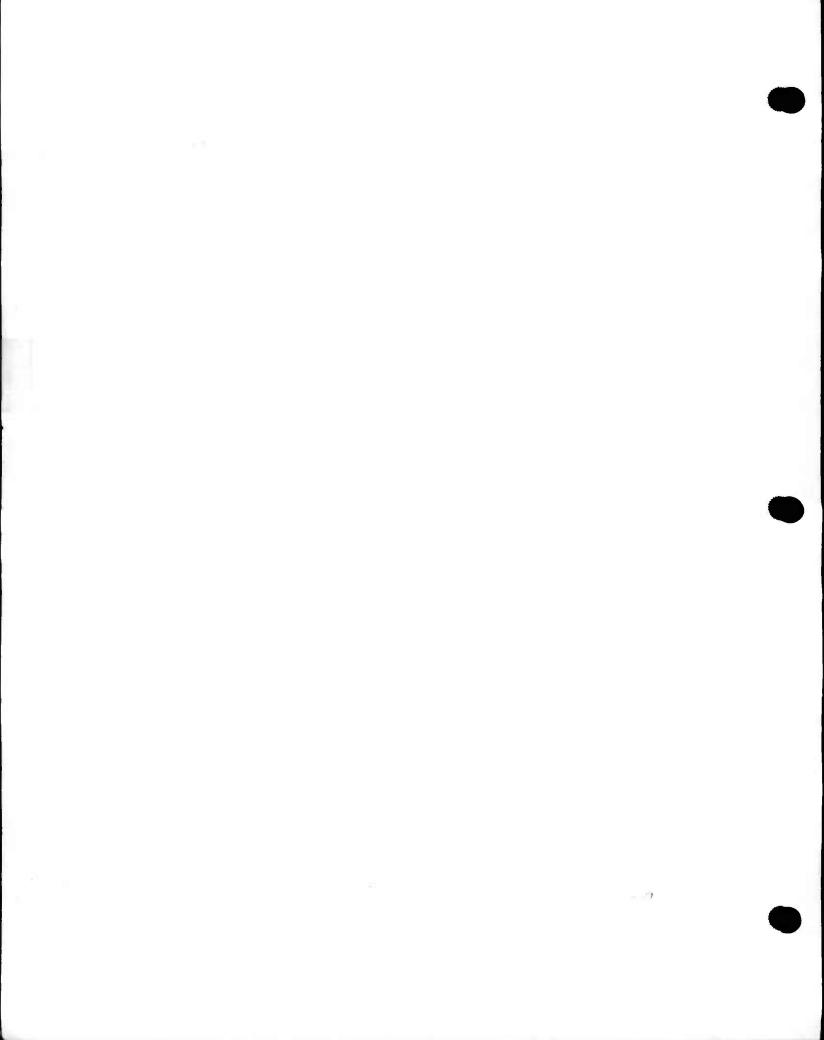
| | | | | | | | 711 - 4 | | | ned. No. | | | |
|--|--|--|--------------------------|---|---|--|--------------|---|--------------|---------------------------------------|------------|--------------------------|--|
| | | 1. DECEDENT'S NAME (First, Mi | - | MARGARE | T, EI | ONA (| GASS. | AWAY | 2.0 | DATE OF DEATH TO | 2-10 | - 9,0 | 3. TIME OF DEATH |
| | 1 | 4. SOCIAL SECURITY NUMBER | | Jassawa 5. SEX 6. A | (In yrs. le | ne biotholm i m | UNDER 1 YE | AR IF UNDER 24 | / UDO 7.0 | ATE OF BIRTH | 70 |) DIDTH | PLACE (State or Foreign |
| | | 215 14 490 | | - 14 | 7 1 | | INTHS DA | | MIN. (F | Month, Dey, Year) - 14-191 | 9 | Country | |
| should | | 9e. FACILITY NAME (If not institu | rtion, give a | treet and number) | 1. | 1 91 | b. CITY, TOY | VN OR LOCATION | | 14-171 | | TY OF DI | EATN |
| 2, 3 s | OR | University o | 7 K | Narylans | HOSE | ortal | Dal | timori | 5 | | | | |
| Jes 1, | DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | | | | OWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| permit. Pages 1, | DIE | MD | | | | Ва | alti | more | | | | | LIMITS? |
| : perm | FUNERAL | 10e. STREET AND NUMBER | | | 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTR | | | | | HAT COUNTRY? | | | |
| ian. transi | NE | 4401 N. | Roge | 12. WAS DECEDENT EV | | Apt Al | | | 2 1 5 | RIGIN? (Specify Yes | US | | - American Indian, |
| physician. bunal-transit | | 1 Never Married 2 Ma | | FORCES? 1 1 | YES 2 | | It yes | specify Cuban, I YES 2 \(\subseteq NO | Mexicen, Pu | | Or 140— | | , White, etc. |
| as the | ВУ | 3 Widowed 4 Divorce | đ | | JII DAI 20 | | 1 | 123 2 110 | эроспу. | | | Specia | Black |
| 73) | TED | 15. DECEDE (Specify only his | | completed) | - (0 | ECEDENT'S US Give kind of work a. Do NOT use n | done during | PATION g most of working | | 18b. KIND OF BUS | SINESS/IND | USTRY | |
| W) | COMPLET | Elementary/Secondary (0-12) | | College (1-4 or 5+) Yes | "" | | ired | 3 | | teach | er | | |
| de de de de de de de de de de de de de d | OM | 17. FATNER'S NAME (First, Middl | le, Lest) | 7 0 3 | | 100 | .1100 | | R'S NAME (F | First, Middle, Melden | | | |
| - | ш | JAMES G | ASSA | WAY | | | | LELI | IA C | GRAY | | | |
| be retained by ge 5 should be notified at | TO B | 19a. INFORMANT'S NAME (Type | | | - | | | | | Number, City or Town | | | |
| ay be re page 5 | | Dewey Rob | | n Pow/A | _ | | | | | Balto., | | | |
| | | 1 Buriet 2 Cremetion Donation 5 Other (Sp. | 3 🗆 Rem | oval from State | other p | OF DISPOSITI | ON (Name o | f cemetery, cremeto | ory or | 20c. LO | CATION — | City or To | wn, State |
| leath. Page 6 m funeral director. xaminer musi | | 21. SIGNATURE OF FUNERAL S | ERVICE LI | Rona V | d Wad | le,Dir | 22. NAM | E AND ADDRESS | OF FACILITY | STATE | ANA | MOT | Y BOARD |
| r death. Pag he funeral di al. | | > Tong | W | 1 MUK | elle | | 65 | 55 W. E | Balto | St,Ba | lto, | MD | 21201 |
| in by the in removal. | | 23. PART I. Enter the dise | ases, of | complications that ca List only one ceuse of | used the d | eeth. Do not | enter the | mode of dying | , such aa | cerdiac or reapl | ratory arr | eat, | Approximate Interval Between |
| filled in b on, or ren | | IMMEDIATE CAUSE (Final | t landle. | ΛΛ. | f | | 7 - | 0. 1. | | | | | Onset and Deeth |
| | | disease or condition resulting in death) | | | Q+ 11 | OUENCE OF): | In! | care to | ch | | | | 490Ar |
| 8 0 m | , | | | Corona | | Jr LC | 1 | | 910 | | | | 2010000 |
| be execut siclan and c rior to buri traumatic | DI I | Sequentially list condition if any, leeding to immedia | te | DUE TO (OR | AS A CONSE | OUENCE OF): | 7 | 2 100 | 0(0 (| | | | - A KAN |
| ficate be physician ne prior t | \ <u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \</u> | cause. Enter UNDERLYING CAUSE (Disease or Injury | · 【 | C. DUE TO (OR | AS A CONSE | QUENCE OF): | | | | | | | |
| death certificate attending physiental Hygiene pri | CERTIFICATION | that initiated events resulting in death) LAST | | 30E 10 (011 | AS A CONSC | GUENCE OF J. | | | | | | | į į |
| the death y the atten of Mental injury, o | | DART II. Other electrons | ann distan | a. | 4b b. 4 - 4 | | | | | . 1 | | 1 | |
| = 0 = | EDICAL | Corovol | TILLO | ry Byno | _ | | tne undar | lying cause giv | en in Part | PERFOR | MED? | 24b | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| requires that een signed by of Health an shows any | EDÍ | COLORAN | 11 14 | 17 12 100 | w . | say c | - | | | 1 TYES 2 | NO | | OF DEATH? |
| w requires been sign pt. of Heal | ¥ : | | | | | | - | | | | | | 1 Tes 2 No |
| SICIAN: The law r certificate has be the State Dept. the State Dept. d, or item 23 s | PHYSICIAN: | 25. WAS CASE REFERRED TO MEXAMINER? | MEDICAL | WOOD!T: | | | | 6. PLACE OF DEA | TN (Check or | nly one) | | | |
| rtificat he Stat or ite | YSIC | 1 TYES 2 NO | | HOSPITAL: | | | THER: | Home 5 - Resk | dence 6 🗆 | Other (Specify) | | | |
| After this ce death with the marked, | | 27. MANNER OF DEATN 1 Natural 5 Per | | 26e. DATE OF INJI (Month, Day, Y | | 28b. TIME (| ny | WORK? | | I. DEŞCRIBE NOW I | NJURY OC | CURED | |
| NDING t: After r death | D BY | 2 C Accident | estigation uld not be | 25s. PLACE OF IN building, etc. | JURY At h | ome, ferm, stre | et, factory, | office | 261. | LOCATION (Street City or Town, State) | | r or Rural I | Route Number, |
| DR ATTENDING DIRECTOR: After hours after death item 28 is ma | ETE | | ermined | | (5), (5), | | | | | O.17 G. 10111, O.1810) | | | |
| TE TE TE TE TE TE TE TE TE TE TE TE TE T | | | | | | | | | | | | s) and menner as stated. | |
| THE HOSPI TO THE FUNER OF filed within | BE C | 296. SIGNATURE AND TITLE OF | F CERTIFIE | (R) < 1.0 | to p | him | 1 | 29c. LICEN | SE NUMBER | | 29d. DAT | E SIGNED | (Month/Day, Year) |
| ₽ ₽ 3 X | 5 | 30. NAME AND ADDRESS OF P | ERSON WI | 10 COMPLETED CAUSE C | F DEATH (IT | EM 27) (Type, P | (// rint) | 1 10 | 06/ | J | / | 2// | 0140 |
| | | Buce Simo | nM | 0 22 3 | Sout | h 62 | cch | 1 54 | rcc- | 1. Bal | 41'm | Ore | Maryland |
| | | 1. DATE FILED (Month Day) | 990 | State Ja. | SIGNATURE | indel | | | | | | | , |



| its or attending providian. | I was as the partal-transit permit. Pages 1, 2, 3 shou |) | | |
|---|--|--|--|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospit | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | TEGIOTIAN | | | | OAIL | . 0. | | | | EG. NO. | | | | |
|--|---|------------------------------|---|-----------------------------|---------------|-----------|--------------------|---------------|------------------------------------|---|--------------|------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) CHARLE | = 6 | ARD. | NE | e | | | | 2. DATE OF S | DEATH DA | Y | YEAR | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF E | | 9 | | IPLACE (State or Foreign | |
| | 216-07-5474 | 1√2 M 2 □ F | 73 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, 9e | 7 /17 | 7 | Countr | MD | |
| | 9a. FACILITY NAME (If not institution, give s | | 9b. CITY, | TOWN | OR LOCATI | ON OF DE | EATH | / | 9c. COU | INTY OF D | | | | |
| DIRECTOR | HARBOR HOSPIT | | | BA: | LTIM | ORE | | | | | - | | | |
| S S | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN O | R LOCAT | TION | | | | - | | 10d. INSIDE CITY | |
| H | MD ANNE | GLE | V Tal | URNT | E | | | | | LIMITS? | | | | |
| AL | 10e. STREET AND NUMBER | | | | | | . ZIP COD | | | | 10g. CIT | IZEN OF V | VHAT COUNTRY? | |
| FUNERAL | 769 NARRS CRE | | | | | | | 060 | | | | USA | | |
| 3 | 11. MARITAL STATUS 1 Never Married 2 X Married | 12. WAS DECEDEN FORCES? 1 | TEVER IN U.S. A V YES 2 MAR OR DATES | RMED NO | 1 1 | f yes, sp | ecify Cubi | ın, Maxica | NIC ORIGIN? (S in, Puerto Ricer | | or No— | Black | E — American Indian, k, White, etc. | |
| BY | 3 Widowed 4 Divorced | | Y 1943 | | 1 | YES | 2 NO | Specif | y: | | | Spec | WHITE | |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a. D | ECEDENT'S Give kind of v | USUAL OC | CCUPATIO | ON set of worki | 00 | 18b. KIN | D OF BUS | SINESS/IN | DUSTRY | | |
| COMPLETED | Elementary/Secondery (0-12) | College (1-4 or 5 | | e. Do NOT us | e retired.) | 1 640 | | 19 | | | | | | |
| MP | 9 th | | | LONG | SHO | REM. | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | משוגממג | | | | | 18. MOT | | ME (First, Midd) TH HA | | | | | |
| BE | WILLIAM R. G 19a. INFORMANT'S NAME (Type/Print) | ARDNER | -1 | 9h MAILING | ADDRESS | (Street | and Numbe | | Route Number, (| | | in Code) | | |
| 9 | VIOLA B. GARD | NER | | | | | | | | - | | | MD 21060 | |
| | 20s. METHOD OF DISPOSITION | | 20b. PLACE | E OF DISPOS | | | | | | | | City or To | | |
| | 1 C Buriai 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | oval from Stata | CEI | DAR H | ITT.T. | CE | метн | ERY | |] | BALT | LTIMORE | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | X_ 1 | | 22. | NAME A | ND ADDRE | SS OF FA | | NC 1 | CIINIE | דגמי | HOME, INC | |
| | *a Mul | us X | John | | 1 | 501 | E. | FOR | T AVE | .,] | BALI | . O. | MD 21230 | |
| | 23. PART i. Enter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List Dniy Dna cat | use on each lin | na. | ^ | | | 1030000 | 1 | | | | Approximate Interval Between Onset and Deeth | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | (OR AS A CONSI | EQUENCE 9 | F): <i>()</i> | ai | lu | | | | | | | |
| MEDICAL C | PART II. Other aignificant condition | na contributing to | deeth but not | reaulting | in the un | nderiyin | g cause | given in | | . WAS AN PERFOI | | 241 | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | |
| N. | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | ☐ ER/Outpatient | 3 🗆 DOA | OTHE | R: | | smond = | 6 - Other (S | pecify) | | | | |
| λHζ | 27. MANNER OF DEATH | 28a. DATE Of (Month, I | | 28b. TIM | _ | 28c. IN | JURY AT | | 28d. DESCRI | | INJURY O | CCURED | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | М | | YES 2 | □ NO | | | | | | |
| 3 Suicide Suic | | | | | | | | Route Number, | | | | | | |
| COMPLET | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of my knowledge, dasth occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | Cc. | a n | ND | | | 29c. LK | ENSE NU | 407 | 6 | 29d. DA | TE SIGNE | (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAL | SE OF DEATH (IT | EM 27) (Type | Print) | | 70 | 10 | 1 | - | - 01 | 11. | 0.00 | |
| | III / JETINANISI (IV. | - / A/W// | A I COLUMN | VV / | 1-1-1 | - | | , , | 10 10. | | 0 01 | | | |
| | 31. DATE FILED (Month. Day Year) | 30. REGISTR | AR'S SIGNATURE | | 70- | 7 200 | ves | 6 | mer | 1/3 | nu | m | i prodice | |
| | 31. DATE FILED (Month, Day, Year) DEC 1 9 1990 | 34. REGISTA | AR'S SIGNATURE | ndell | 1 | 7-20 | us | | mer | - <u> </u> | u | enn | e prodicts | |



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DEC 12 1990

| | FOR 1 STATE | STATE OF N | MARYLAND / | DEPAR | TMENT O | F HEAL | TH AND ! | MENTAL HYG | IENE | 9 (| 34097 | |
|------------------|--|--|--|-------------------------------------|---|---------------------------------|------------------------------------|---|----------------------|---|--|--|
| | REGISTRAR | | CE | RTIF | ICATE C | F DE | ATH | REG | NO. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEA | TH | Y | 3. TIME OF DEATH | |
| | ELEANOR | Cati | erine | | OLLAND | LLAND DECEMBER | | | | 199 | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | MONTHS DAVE HOUSE AND (Month, Day, | | | | 7. DATE OF BIRT (Month, Day, Ye | ar) | | BIRTHPLACE (State or Foreign Country) | | |
| | 138-16-3387 | 1 M 2 F XX | YRS. | | | | 11-30 | -20 |) | N.J. | | |
| _ | 9e. FACILITY NAME (If not institution, give street end number) THE JOHNS HOPKINS HOSPITAL | | | | | | CATION OF DE | ATH | 1 | e. COUNTY | OF DEATH | |
| 6 | RESIDENCE OF DECEDENT | HUSPITA | և | | BALT | IMOR | E. | | L | BAL' | TIMORE CITY | |
| <u> </u> | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR LO | CATION | | | | | 10d. INSIDE CITY | |
| 뜻 | WD. | | | BA | LTIMO | RE C | CITY | | | | LIMITS? | |
| FUNERAL DIRECTOR | MD 10e. STREET AND NUMBER | | | | | 10f. ZIP | CODE | | 1 | IOg. CITIZEI | N OF WHAT COUNTRY? | |
| E | 506 NORTH CHES | יידי כייו | ਾਰਚਾ | | | 2.1 | 205 | | | I | JSA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. AR | MED | 13. WAS | DECENDE | NT OF HISPAN | IIC ORIGIN? (Spec | fy Yee or | No 14 | . RACE — American Indien, Bleck, White, etc. | |
| | 1 Never Merried Z Merried | IF YES, GIVE V | YES 24 A | 10 | 1 🗆 | YES 2 | NO Specifi | n, Puerto Rican, et | c.) | | Specify: | |
| ВУ | 3 Widowed 4 Divorced | | | | | | | | | | BLACK | |
| 三 | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (G | CEDENT'S ve kind of Do NOT us | USUAL OCCUI | PATION g most of t | working | 16b. KIND C | F BUSIN | ESS/INDUS | TRY | |
| <u>"</u> | Elementery/Secondery (0-12) 9th Grade | College (1-4 or 5 | F) | mes | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 146 | MOTHER'S NA | ME (First, Middle, A | foiden Cu | rmama) | - | |
| ö | Henry | Mc | Carthy | | | 100. | _ | | | | stan | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | | . MAILING | ADDRESS (St | eet end Nu | Ruth umber or Rural | Route Number, City | or Town. | State, Zip Co | eton ode) | |
| 2 | Jacqueline | Garne | r 5 | 302 | Agin | cour | rt Ter | race | / R : | ichm | ond, Va. 23237 | |
| | 20e. METHOD OF DISPOSITION | oval from State | 20b. PLACE other ph Balt | of dispo | re Ce | metery | ery | | | | re, Md. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 1 | | 22. NAN | E AND A | DRESS OF FA | CILITY | | | | |
| | (alun L | Wille | amb | | WM. | С. | MARC | н г.н. | 110 | 01 E | . NORTH AVE. | |
| | 23. PART I. Enter the diseases, or of shock, or heart failure. | | | | not snter the | mode o | f dying, suc | h se cardiac or | respira | tory erres | t, Approximata interval Between | |
| | IMMEDIATE CAUSE (Final | List Only One Cat | Joa Oli Gaoli Illie | • | | | | | | | Onset and Death | |
| | diseese or condition resulting in desth) | Ische | me ! | Downe | l. | | | | | | 12845 | |
| | The second second | DUE TO | (OR AS A CONSE | QUENCE O | F): | p.; | | | | | . 9 | |
| Z | Sequentielly list conditions, Due To long as a Consequence on: | | | | | | | | | | | |
| CERTIFICATION | if sny, leading to immediata cause. Enter UNDERLYING | | on security | T | 1 | 1. 41 | 6.00 | | | | 1,0 | |
| FIC | CAUSE (Diseese or Injury | c. CO-FD V | OR AS A CONSE | DUENCE O | Fi: | orde | E M | | | | 42/12 | |
| Ē | that initiated events resulting in deeth) LAST | 5004000 | | | PT: 11977 | | | | | | 0 | |
| CE | | d | | | | | | | | | | |
| AL | PART II. Other significant condition | s contributing to | deeth but not i | esulting | in the under | fying ca | use given in | | AS AN AL | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| S | COLD | | | | | | | 1 1 | /ES 2 [| NO | COMPLETION OF CAUSE OF DEATH? | |
| MEDICA | Ho his | | | | | | | | | | 1 TES 2 NO | |
| ä | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | 6. PLACE | OF DEATH (C) | neck only one) | | | | |
| YSI | 1 TES 2 TONO | 1 [[inpatient 2] | ER/Outpatient 3 | | 4 🗆 Nursing | Home 5 | Residence | 6 Other (Speci | | | | |
| F | > | | | | | | | 26d, OESCRIBE | HOW INJ | IURY OCCU | RED | |
| ВУ | 1 De Netural E Danding | 1 Natural 5 Pending | | | | | M 1 YES 2 NO | | | | | |
| | | | | | | | | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| TED | | 26e. PLACE (| DF INJURY — At he etc. (Specify) | ome, farm, | | | | 281. LOCATION (City or Town | Street and State) | d Number or | Rural Route Number, | |
| APLETED | 2 Accident 3 Suicide 6 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS) | 26e. PLACE (building | f my knowledge, de | ath occur | atreet, fectory, | office | | City or Town | State) | er as stated | ı. | |
| COMPLETED | 2 Accident 3 Suicide 6 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS) | 26e. PLACE (building | f my knowledge, de | ath occur | atreet, fectory, | office | | City or Town | State) | er as stated | | |
| SE COMPLETED | 2 Accident 3 Suicide 6 Could not be datermined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS) | 26e. PLACE (building) | f my knowledge, de | ath occur | atreet, fectory, | office date and on, death | | City or Town | State) nd menn | er as stated due to the | ı. | |
| | 2 Accident 3 Suicide 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 25e. PLACE (building) CIAN: To the best of circ. On the basis of circ. | f my knowledge, department of my knowledge, department on end/or | eath occur Investigati | atreet, fectory, red at the time, on, in my opini | date endion, death | occured at the | City or Town | nd menn | er as stated due to the 29d, DATE : | i. ceuse(e) end menner ee stated. | |

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permit. Pages 1, 2, 3 should

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CERTIFICATION

PHYSICIAN: MEDICAL

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FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

088 09 6269

10e. STREET AND NUMBER

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

20e. METNOD OF DISPOSITION

11. MARITAL STATUS

10a. STATE

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| py requires that the obath cerumcare be executed within 24 hours after death. Fage o first be retained by the hospital of attending ph | as been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu | | : If item 28 is maged or new 3 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| IJ e | the | pet. of Health and Mental Hygiene prior to burial, cremation, or removal. | F |
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| X A | RAL DIRECTOR: A | 1 72 hours after death with the | E 5 |
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| Z. | R | 17 | = 3 |

90 34098 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATN Anne Hall pm 6 -1990 Nou: 21 5. SEX 7. DATE OF BIRTH
(Month, Day, Year)
Jan. 18, 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 1 M 2 V 82 YRS. 1908 Austria 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN Holy Cross Hospital Silver Spring Montgomery RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10b. COUNT 10d. INSIDE CITY LIMITS? Washington none 1X YES 2 NO 10f. ZIP COOE 10g, CITIZEN OF WHAT COUNTRY? 2801 Quebec Street, N. W. Apt. 745 20008 United States 12. WAS DECEOENT EVER IN U.S. ARMED 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 X NO Specify: FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: White 15. DECEDENT'S EDUCATION 16a. DECEOENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Defense Intelligence Agency years Executive Secretary 17. FATHER'S NAME (First, Middle, Last) 18. MOTNER'S NAME (First, Middle, Maiden Surname) Samuel Handwerker Sali Gottesman 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) Arthur J. Whalen, Jr. 417 Windson Street, Silver Spring, Maryland 20910 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION - City or Town, State 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY DONALD M.STEIN HEBREW MEMORIAL FUNERAL HOME Donald 232 CARROLL STREET, N.W., WASHINGTON, D.C. 23. PART I. Entar tha dieeesee, or complications that caused the de . Do not enter the mode of dying, such se cerdiac or respiratory erreat, Approximate ehock, or haart failure. List only one cause on each line Interval Between Oneet end Deeth cerehovaseule 6 mouth DUE TO (OR AS A CONSEQUENCE OF): approprieta QUE TO (OR AS A CONSEQUENCE OF):

IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions. If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not reculting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE

25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO patient 2 - ER/Outpatient 3 - DOA me 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. OATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO

1 TYES 2 NO

2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, streel, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be 4 Homicide determined 29e. CERTIFIER

(Charle police)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated.

2 MEDICAL EXAMINER: On the beels of examination end/or investigation, in my opinion, death occursed at the time, date end place, end due to the ceuse(e) end manner es steted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, OATE SIGNEO (Month, Day, Year)

Blaulish, m. D. Bach D26900 (Mu) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Barbara Blaylock M.D. 16111 Executive Blvd. 708 (-2 Ruchville.

31. OATE FILED (Month, Day, Year) DEC 12 1990

congestive heart failur

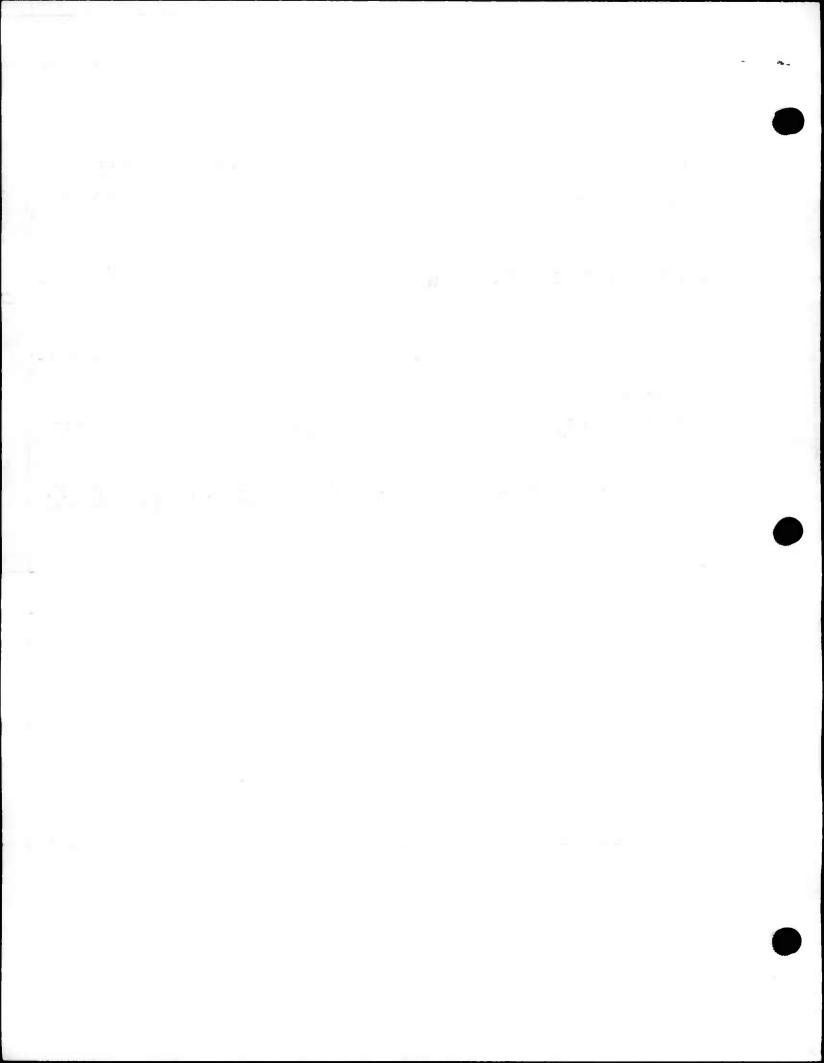
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hia Davidson-Bandale

OF DEATN?

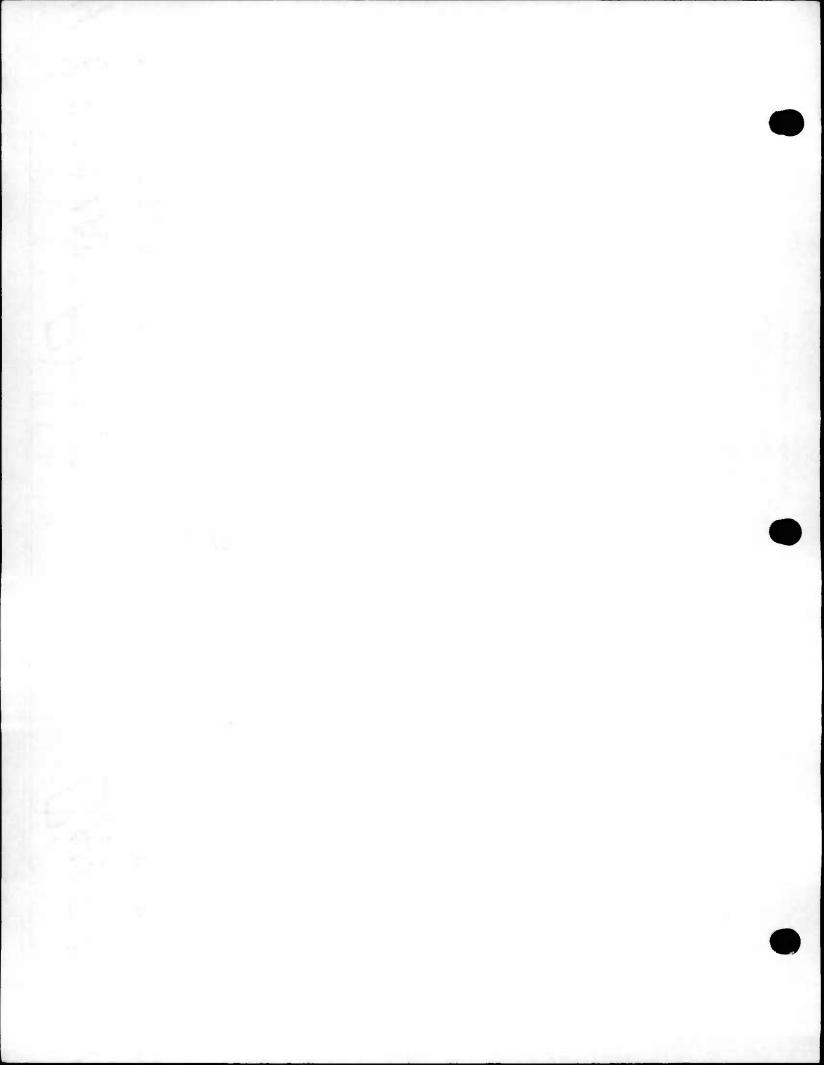
11/2

1 YES 2 NO



| ler death. Page 6 may be retained by the hospital or attending physician. | s centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thin State Deot, of Health and Mental Hygiene prior to burial, cremation, or removal. | si examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|---|---|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE EXNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the further family after death with the State Degr. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT, if item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

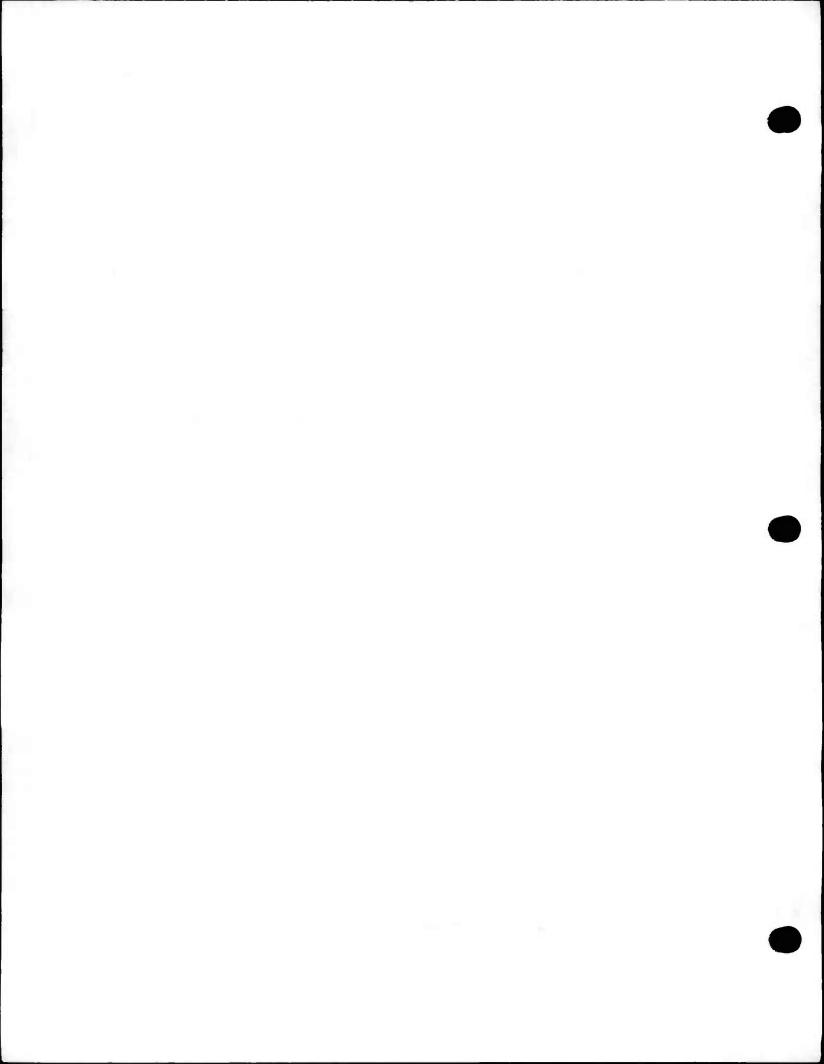
| 1 - STATE REGISTRAR | STATE OF M | CERT | FICAT | E OF | DEAL | п | | REG. NO. | | | | |
|--|--|--|--|---|---|------------------|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last MILDRE | о М. | HULLETT | | | | | 2. OATE MONTH | of DEATH |) 19 | 90 | 3. TIME OF OEATH | |
| 4. SOCIAL SECURITY NUMBER 214-01-1085 90. FACILITY NAME (If not institution, give | 1 M 2 K F | 8. AGE (In yrs. last birthda 75 YRS | MONTHS | ry, TOWN O | | MIN. ON OF DE | (Month | Dey, Year) | | RA1 | timore Md | |
| 1123 HOLLINS RESIDENCE OF DECEDENT 100. STATE 10b. COUN | | 100 | CITY, TOWN | | IMORI | E | | | | _ | 10d. INSIDE CITY | |
| MARYLAND 10s. STREET AND NUMBER | | | BALTI | IMORE | | | | | 10a CITIZE | EN OF V | LIMITS? 1 YES 2 NO WHAT COUNTRY? | |
| 1123 HOL | LINS STREE | T EVER IN U.S. ARMED | 12 | | 21223 | 3 | ALC OBIGIN | ? (Specify Yes | U.S | .A. | E — Amaricen Indien, | |
| 1 Never Married 2 Merried 3 Wildowed 4 Divorced | | YES 2 NO | | If yes, spe | cify Cuban 2 ⊠ NO | ı, Mexica | n, Puerto I | r (Specify fet tican, etc.) | 1 OF NO. | Speci | k, White, etc. Hy: | |
| 15. DECEDENT'S ED (Specify only highest gra- Elementary/Secondary (0-12) | | | r's usual of work done T use retired. dinat | e during mos .) | N st of working | g | | rds Ba | | STRY | | |
| 17. FATHER'S NAME (First, Middle, Last) John T. HUrley 190. INFORMANT'S NAME (Type/Print) | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme) John T. HUrley Margaret (Unknown Last | | | | | | | | NAme) | | | |
| JoAnn Zanella | - | 112 | 3 Hol | llins | St. | , Ва | | ore, N | D. 2 | 21223 | | |
| 1 XBuriel 2 Cremation 3 Re 4 Donation 5 Other (Specify) | | other place) | Loudon Park Mausoleum | | | | | Baltimore | | | | |
| H. SIGNATURE OF FUNERAL SERVICE POENSEE HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTI | | | | | | | TC. | | | | | |
| 23. PART I chter the diseases, o shock, or heart fellure IMMEDIATE CAUSE (Final | r complications that b. List only one cause | caused the death. D | | 4107 | WILK | ENS | AVEN | UE, BA | ALTIMO | | Approximate Interval Between | |
| shock, or heart fellure | e | Caused the death. Do no each line. OR AS A CONSEQUENCE OR AS A CONSEQUENCE OR AS A CONSEQUENCE | o not ente | 4107 | WILK | ENS | AVEN | UE, BA | ALTIMO | | Approximate Interval Between | |
| immediate Cause (Final disease or condition resulting in death) Sequentiely list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | e | OR AS A CONSEQUENCE | CON E OF): | 4107 or the mod | WILK | ENS | AVEN | UE, BA | ALTIMO iratory arre- iratory a | ise Per | Approximate Interval Between Onset and Deat | |
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| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions in death and immediate cause. Examiner? 1 | B. List only one cause B. DUE TO (C. DUE TO (C. DUE TO (DUE | DR AS A CONSEQUENCE OR AS A C | O not enter (C/M E OF): E OF): E OF): TIME OF INJURY M m, street, fa | underlying 28. PL ER: uraling Hom 28c. INJ actory, office | WILKI de of dyli R L G Course g G Course g ACE OF DI BY AT FIRST PES 2 Beath occur 29c. LICE | ENS ng, suc | Part I. Part I. 28d. DE: | 24a. WAS AN PERFO! 1 YES 2 ATION (Street or Town, State, use(a) and ma | ALTIMO iratory arre- iratory a | 24b 24b Add. cause(| Approximate Interval Between Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onset and Deat Onse | |



| NDING PHYSICIAN: The law requires that the death certificate be executed within 2. Surs after death. Page 6 may be retained by the hospital or attending physician. | R; After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | er death with the State Dept. of Health and Mental Hyplene prior to burfal, cremation, or removal. | APORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The | IN THE FUNERAL DIRECTOR; After this certificate ha | Mind within 72 hours after death with the State D | MPORTANT: If Item 28 is marked, or Item |

| | FOR 1 - STATE REGISTRAR | STATE OF M | | | TMENT ICATE | | | | | YGIEN | e 90 | 3 | 4100 |
|--------------------|--|--|---------------------|------------------------|------------------------------|----------------|--------------|-----------|------------------|---------------------------|--------------------------|----------------------|----------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | WILLIAM E | B. HUTH | Lu | Th | | | | 2. DATE OF MONTH | DA | | 3. 1 90 | 12:30 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER 1 | YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF I | | | BIRTHPLA Country) | CE (State or Foreign |
| | 215-28-5777 | 1/M 2 🗆 F | 60 | YRS. | | 25002 | | (E-12 | June | | 1930 | YLAND | |
| ~ | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, | TOWN O | R LOCATIO | ON OF DE | ATH | • | 9c. COUNTY | OF DEATH | 1 |
| 0 | ST JOSEPH HOSPI | TAL 762 | O YORK | RD | TO | WSC | M, M | D | 21204 | | BALT |) CO | UNTY |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OF | LOCAT | ION | | | | | 100 | . INSIDE CITY |
| 5 | MD BAT.TT | MORE CO | עייעוו | η. | OWSO: | N M | D | | | | | 1 [| LIMITS? |
| AL. | 10e. STREET AND NUMBER | | | | | | ZIP COD | E | | | 10g. CITIZEN | OF WHAT | COUNTRY? |
| FUNERAL | 17043 GERTUNG | RD | | | | МС | NKT | ON.I | MD 21 | 111 | U.S | 5 . A. | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT FORCES? 1 | | | | | | | NIC ORIGIN? (S | | or No- 14. | RACE - | American Indian, nita, atc. |
| À | 1 Naver Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | | | | Specify | | | 1.77 | Specify: | |
| | 15. DECEDENT'S EDUC | | 16a, DE | CEDENT'S | USUAL OC | CUPATIO | A N | | 16b. KII | ID OF BU | VV 1 SINESS/INDUS | HITE | |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 + | life | he kind of Do NOT u | work done do se retired.) | uring mo | st of workii | ng | | | | | |
| 린 | 12 yrs | | S | e1f | Emp10 | yed | | | De | ve1c | per | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | rr .1 | | | | | | | ME (First, Midd | le, Maiden | | | |
| 8 | Frank | Huth | | | | | | mie | | | | erry | |
| 2 | 194. INFORMANT'S NAME (Type/Print) Norma Joan Huth | | 19 | | | | | | | , | vn, State, Zip Co. 21111 | | |
| Ì | 20a_METHOD OF DISPOSITION | | 20b. PLACE | _ | | | | | JIK COII | | CATION — CIT | | State |
| | 1 Burial 2 Cremation 3 Remarks Donation 5 Other (Specify) | | St. J | ames | Epis | сор | a1 1 | 2-10 | | | ikton, | | State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | Land | 11 | | Ru | ıck | Tows | | uneral | | ne, Ind Md. 212 | | |
| | 23. PART I. Enter the disasses, or called the shock, or heart failure. | | | | not anter t | the mo | de of dy | ing, suc | h as cerdled | or resp | Iratory erree | t, | Approximate |
| | IMMEDIATE CAUSE (Final | s. Acu | | | vel | ie C | 7 | 27 | PARC | to | ٠, | | Interval Between Onset and Deeth |
| N | Sequentially list conditions, | , , | OR AS A CONSE | | 1 | | | | | | | | |
| CERTIFICATION | If any, lasding to immediate cause. Enter UNDERLYING | OUE TO | (OR AS A CONSE | DUENCE C | IF): | | | | | | | | |
| FIC | CAUSE (Disease or injury that initiated events | c. DUE TO | (OR AS A CONSE | DUENCE (| OF): | | | | | | | | |
| E | resulting in death) LAST | d. | | | | | | | | | | | |
| | PART II. Other significent condition | e contributing to | death but not | eaultine. | In the un | dorlylo | 2 001100 | alven la | Part I 24 | - WAC AL | NAUTOPSY | T ash we | RE AUTOPSY FINDINGS |
| S | 14 | | perl | | | ootiyiii. | g cousa | Aison in | | PERFO | RMED? | AVI | MILABLE PRIOR TO |
| | 117/2001 | | | 000 | c C co | _ | | | - ' | YES : | SONO | OF | DEATH? |
| ∑ | | | | | | | | | - | | | 1 | YES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 28, PI | ACE OF I | DEATH (Ch | neck only one) | | | J | |
| SIC | EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHER 4 - Nurs | | 6 5 🗆 R | asidance | 6 Other (S | pecify) | | | |
| PHYSICIAN: MEDICAL | 27. MANNER OF DEATH | 28a. DATE OF (Month, D | | 28b. TII | ME OF JURY | 28c. INJ WC | URY AT | | 28d. DESCR | IBE HOW | INJURY OCCUI | RED | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | | | | M | | YES 2 [| _ NO | | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26a. PLACE O building, | otc. (Specify) | ome, farm, | street, facto | ory, offic | • | | | ON (Street fown, State | and Number or) | Rural Route | Number, |
| LET | 29a. CERTIFIER | ICIAN. To the head of | and beautiful at a | 46 | | | and star | | | Andrew Comme | | | |
| COMPLETED | one) | ICIAN: To the best of ER: On the basis of a | | | | | | | | | | | d menner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | | | ENSE NU | | | | | onth, Day, Year) |
|) BE | Dear 8 7 | Love | 0 00 | 0 | | | | - | 006 | | > / | 2/ | 7/90 |
| 5 | 30, NAME AND ADDRESS OF PERSON WI | O COMPLETED CAU | SE OF DEATH (ITE | M 27) (5m | a Print) | _ | / | _ | | | <u> </u> | $\overline{}$ | 1 |

7600 Osler Drive Towson MAYland



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chia Savidson-Bindall

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DEC

31. DATE FILED (Month, Day, Year)

BALTIMORE, MARYLAND 21203-3146 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within as after death. Page 6 may be retained by the hospital or THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | | | | | | | | |
|-----------------------|---|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2. DATE OF DEATH MONTH : DAY | 3. TIME OF DEATH | | | | | | | |
| | Delores C. Hicks | 12/9 | 90 5:00 am | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 1 M 2 X F YRS. MONTHS DAYS MOURS MIN. 1 M 2 X F YRS. MOURS MIN. 1 M 2 X F YRS. MOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) MARYLAND | | | | | | | |
| | 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF D | 11-1-1-1 | COUNTY OF DEATH | | | | | | | |
| TOR | BON SECOURS HOSPITAL BALTIMORE | P | BALTIMORE CITY | | | | | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Batto | | 16d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | | | | |
| FUNERAL | 10a. 636 Glenwood Ave 10f. ZIP CODE 2/2 | | CITIZEN OF WHAT COUNTRY? | | | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPA II Yes, specify Cuben, Mexical II YES 2 NO Specify | | D— 14. RACE — American Indian, Black, White, stc. Specify: Black | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16s. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | Rosewood | d State Hosp | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) Samuel Boursett Sara | AME (First, Middle, Maiden Surnar | ne) 626 | | | | | | | |
| TO BE | Pandora Hicks 196. MAILING ADDRESS, (Street and Number or Parallel Glenwood) | Ave Balto, | e zip cog (29 GLENWOOD Md 2/2/2 | | | | | | | |
| | 20s_METHOD OF DISPOSITION 1 Burlal 2 Cremetion 3 Removal from Stals Donation 5 Other (Specify) | CEM 20c. LOCATIO | In the | | | | | | | |
| | 21. SIGNATURE GE FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF F | ACILITY West | sh Ave | | | | | | | |
| | 23. PART I. Enter the diseases or complications that caused the deeth. Do not enter the mode of dying, sur shock, or hasnt failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) PANCREATIC A DUE TO (OR AS A CONSEQUENCE OF): | ch ee cerdiac or reapirator | y srrest, Approximate interval Between Onset and Death | | | | | | | |
| TION | Sequentially list conditions, if any, leading to immediata DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| S | CAUSE (Diseasa or Injury | | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | 7119-945-0 | | | | | | | |
| PHYSICIAN: MEDICAL CI | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in | 1 Part I. 24a. WAS AN AUTO PERFORMED? 1 □ YES 2 ☑ N | AVAILABLE PRIOR TO | | | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL 28, PLACE OF DEATH (C | theck only one) | | | | | | | | |
| SICI | EXAMINER? 1 YES 2 NO | | | | | | | | | |
| ЭНХ | 27. MANNER OF DEATH 26s. DATE OF INJURY 28b. TIME OF 10. INJURY AT (Month. Day, Year) INJURY WORK? | 28d. DESCRIBE HOW INJURY | Y OCCURED | | | | | | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | |
| | 3 Suicide 6 Could not be delarmined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | 281. LOCATION (Street and Nu City or Town, State) | imber or Rural Route Number, | | | | | | | |
| COMPLETED | 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and du one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the | | | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NO. | | . DATE SIGNED (Month, Day, Year) | | | | | | | |
| TO BE | L. SAYYUR H.D. | • | 12/9/90. | | | | | | | |

RAVEN BLUD

BALT.

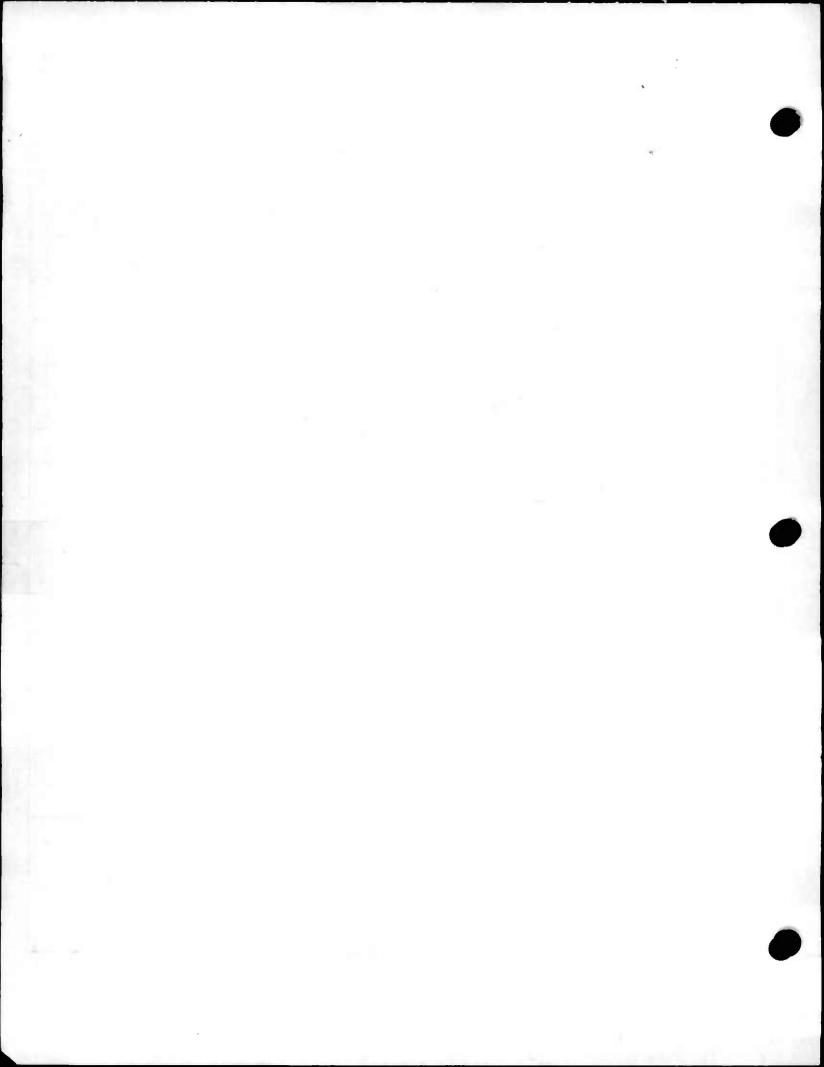
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should man hyperic physician bunal, cremation, or removal. inficate be executed within 👡 nours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death conficulty be executed within consistent death. Page 6 may be retained by the host TO THE FUNERAL DIRECTOR: After this certificate has been signed by the many physician and completely filled in by the funeral director, page 5 should be detached information, or removal.

The funeral death with the State Dept. of Health and Mental Honers prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any valury, of other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | E OF MARYLAND | | | F DEATH | | i. NO | | 3. TIME OF DEATH | |
|--------------------|--|--|--------------------|---|--|-------------------------|----------------|--|--|--|
| ! | 1. DECEDENT'S NAME (First, Middle, Last) Nathaniel | Λ | Hayes | | | MONTH DAY YE | | | 4:45PM M | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | A . 6. AGE (In yrs. | | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7. DATE OF BIR | | 6. BIRT | HPLACE (State or Foreign | |
| 1 | 214-68-4923 1XD M | | YRS. | MONTHS DAY | | (Month, Day, 1 | 6ar) 22-196 | Coun | (try) | |
| œ | 9e. FACILITY NAME (If not institution, give street and number) 802 N. Washington | | | | n on Location of D timore Ci | EATH | | COUNTY OF | Md DEATH | |
| CTO | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c CIT | Y. TOWN OR LO | | | | | 10d. INSIDE CITY | |
| DIRE | Md | | 100. 011 | Baltin | | | | | LIMITS? 1 X YES 2 NO | |
| FUNERAL DIRECTOR | 3735 W. Belvedere | Avenue | | Y | 21215 | | | CITIZEN OF | WHAT COUNTRY? | |
| B | 1 V News Harried 2 Married FOR | DECEDENT EVER IN U.S. CES? 1 YES 2 [ES, OIVE WAR OR DATES | | If yes | DECENDENT OF HISPA , specify Cuben, Mexic (ES 2 NO Speci | en, Puerto Rican, e | | Bia | CE — American Indian, ck, White, etc. city: Black | |
| COMPLETED | 15. DECEDENT'S EOUCATION (Specify only highest grade completed Elementary/Secondary (0-12) College | 16a. | | USUAL OCCUP work done during se retired.) | ATION most of working | 16b. KINO | OF BUSINESS | S/INOUSTRY | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, | | me) | | |
| BE C | Nathaniel Hayes | | | | | Burnet | | | | |
| 5 | 190. INFORMANT'S NAME (Type/Print) Rosalina Burnett | | 196. MAILING | 00 W. I | set and Number or Rural Belvedere | Avenue | or Town, Stat | timore | Apt 415 e, Md 21215 | |
| | 2qs. METHOD OF DISPOSITION 1 Dispose Disposition Dispose Dis | State 20b. PLA | ce of dispo | Star Co | cemetery, cremetory or emetery | | Cato | | Town, State I e , Md | |
| | 21. SIGNATURE OF EUHERAL SERVICE LICENSEE | Cal | | T 22 NAM | ch F/H We | est esh Aven | ue. | | | |
| _ | 21. PART I. Enter the diseases, or complication | D . | death De | | | | | D. arread | Approximata | |
| | shock, or hasrt fallure. List onl IMMEDIATE CAUSE (Final | | OF C | HEST | | | | | Interval Batwean Onset and Death | |
| ATION | Sequentially list conditions, if smy, lasding to immediate | DUE TO (OR AS A CON | ISEQUENCE (| OF): | | | | | | |
| CERTIFICATION | cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. | | | | | | | | | |
| | PART II. Other aignificant conditions contr | buting to death but n | ot resulting | in the under | lying ceuse given i | | WAS AN AUTO | | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| PHYSICIAN: MEDICAL | | | | | | | YES 2 N | | COMPLETION OF CAUSE OF DEATH? XXXX YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 6. PLACE OF OEATH (C | Check only one) | | | | |
| SIC | | PITAL: patient 2 - ER/Outpatien | nt 3 🗆 DOA | OTHER: | Home 5 - Residence | Other (Spe | offy) ho | ouse | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | | UJURY M | WORK? | 28d. DESCRIB | E HOW INJUR | | | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | | , street, factory, | office | City or Tow | (Street and Non, State) | ITY, | A Route Number, A SHINGTON ST MARYLAND | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To MEDICAL EXAMINER: On the | | | | | | | | be(a) and manner se stated. | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER WORLD WAR | ght | | | 29c. LICENSE N | | 290 | | 2-10-90 | |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMP DONALD WRIGHT, MD | LETED CAUSE OF CEATH | | 0:0-1 | Street,Ba | ltimore | ,MD 21 | 201 | V | |
| | | Laryason-Rang | RE | | | | | | | |



the burial-transit permit, Pages 1, 2, 3 should

BALTIMORE, MARYLAND

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY FUNERAL DIRECTOR

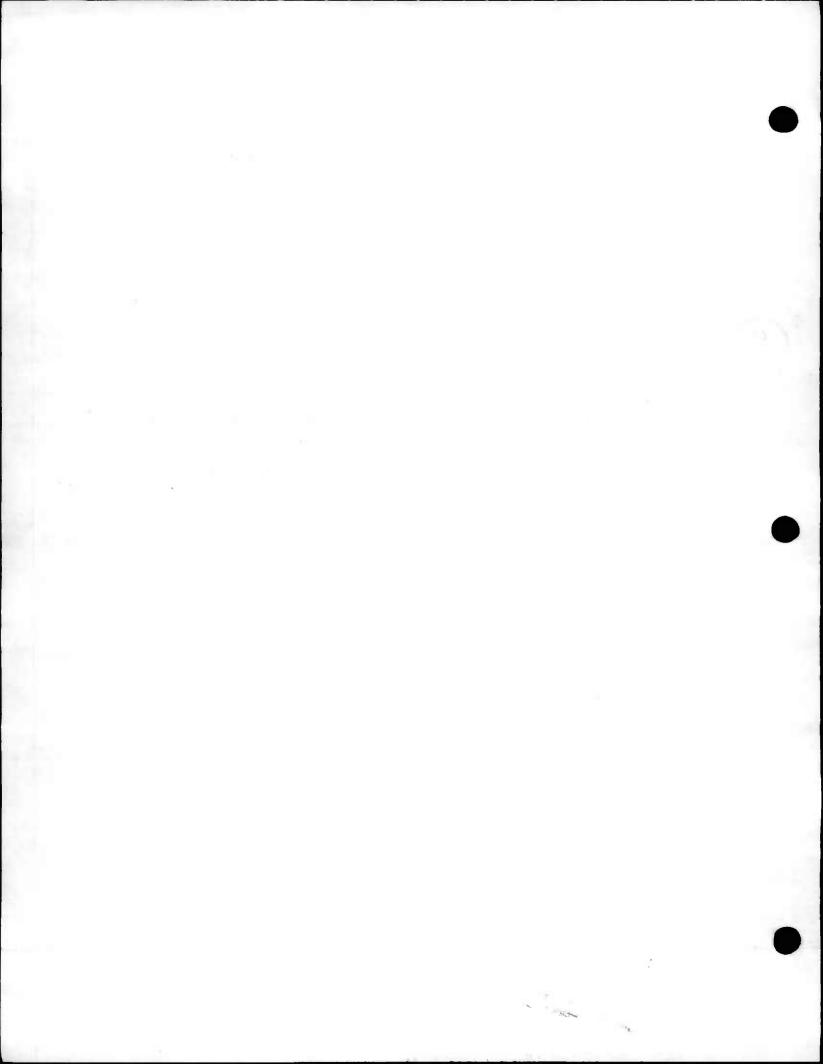
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at unit TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within computed from the figure of the function of the functio

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DEC 1

2 1990

| 1 - STATE REGISTRAR | STATE OF MAR | | ERTIFI | CATE (| OF DEATH | | REG. NO | | | |
|--|--|------------------|--|---|--|---|--|---|--|---|
| 1. OECEOENT'S NAME (First, Middle, Last) | 1.0 | | | | | | ATE OF OFATH | | э. Т | IME OF DEATH |
| Hambis erm | Vernon | E | Hum | /m _ | 1 | | I D | AY 4 | O | 1507 M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. A | GE (In yrs. les | st birthday) | IF UNDER 1 YI | AR IF UNDER 24 H | RS. 7. D | ATE OF BIRTH | 14 | BIDTHOI A | CE (State or Foreign |
| | 12 M 2 □ F | 1 | YRS. | MONTHS D | NYS HOURS MI | N. 4 | Month, Day, Year) | | Country M | d. |
| 9e. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, TO | WN OR LOCATION O | F DEATH | 1 1 0 3 | 9c. COUNTY | OF DEATH | ī |
| Universit | y Hospita | al | Į | Ва | lto. | | | | | |
| DECIDENCE OF SECEDENT | 77 | | | | | | | 1 | | · · · · · |
| 10e. STATE Md . 10b. COUNTY | | | | , town on L altim | | | | | | LINSIDE CITY LIMITS? YES 2 NO |
| 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CITIZEN | | |
| 7238 Jimrowe | Ct. | | | | 212 | 37 | | J | J.S. | Α. |
| 11. MARITAL STATUS | 12. WAS DECEDENT EV | | | | OECENDENT OF HI | | | s or No— 14. | RACE - A | American Indian, lite, atc. |
| XX Never Merried 2 Merried | FORCES? 1 1 1 | | NO | | s, specify Cuban, Me YES 2 ANO S | exican, Pu | erto Rican, atc.) | | | ite, etc. |
| 3 Widowed 4 Divorced | | | | _ | | ,,. | | BI | ľäčk | |
| 15. DECEDENT'S EDUC (Specify only highest grade | | | | USUAL OCCU | PATION ng most of working | | 18b. KIND OF BU | SINESS/INDUST | TRY | |
| Elementary/Secondery (0-12) | College (1-4 or 5+) | - IMa | . Do NOT us | e retired.) | ng most or working | | | | | |
| 1 | | j | infa | nt | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER | S NAME (F | first, Middle, Maider | Surneme) | • | E 1021 |
| Vernon E. | Hamlin. | Sr. | | | Nur | ncit | a | 1 | Morr | is |
| 19a. INFORMANT'S NAME (Type/Print) | | | b. MAILING | ADDRESS (S | treet end Number or F | Bural Floute | Number, City or Tov | vn, State, Zip Co | de) | |
| Vernon Hamlin. | Sr | 1 | 72 | 38 Ji | mrowe (| lt. | Balto | Md . | . 21 | 237 |
| 20e. METHOD OF DISPOSITION | | 20b. PLACE | OF OISPOS | SITION (Neme | of cemetery, cremator | y or | 20c. LC | CATION - City | or Town | State |
| XXBuriel 2 Cremation 3 Rem | oval from Stata | Kii | ng M | emori | al Park | 2 | В | alto. | , Md | • |
| 21, SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | | ME AND ADDRESS C | | | | | |
| | - 42 | - | | TE | mes A. | Mox | ton c | Sone | | |
| V// 1212 N // | | | | 00 | unes A. | MOT | COII & | 20112 | | |
| XULLAND O | , / / // | wn | / | 17 | 01 Lau | cens | ST. B | alto. | _ | . 21217 |
| 23. PAN I. Enter the disesses, or can shock, or heart failure. | | | | 17 | 01 Lau | cens | ST. B | alto. | _ | Approximete |
| shock, or heart failure. | List only one cause of | on each line | ●. | 17 | 01 Lau | cens | ST. B | alto. | _ | |
| shock, or heart failure. | List only one cause of | on each line | ●. | 17 | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. | | on each line | ●. | 17 | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. | List only one cause of | CAUSE AS A CONSE | equence of | 17 | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, | e. Unknown DUE TO (OR b. Chm, Z | CAUSE AS A CONSE | equence of | not enter the | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentiely list conditions, if any, leading to immediate cause. Enter UNDERLYING | e. Unknown DUE TO (OR b. Chm, Z | CAUSE AS A CONSE | equence of | not enter the | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate | e. UKCUA DUE TO (OR DUE TO (OR C. | CAUSE AS A CONSE | EQUENCE OF | not enter the | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | e. UKCUA DUE TO (OR DUE TO (OR C. | CAUSE AS A CONSE | EQUENCE OF | not enter the | 01 Lau | cens | ST. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | e. Unfracture of the total of t | AS A CONSE | equence of | not enter the | Ol Laus mode of dylng, | cens such ee | SE. B | alto. | _ | Approximete interval Between |
| shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent condition | e. Unfactor over to contributing to des | AS A CONSE | equence of | not enter the | Ol Laus mode of dylng, | cens such ee | ST. B cerdiec or resp | alto. | 24b. WE | Approximete interval Between |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) PART II. Other eignificent condition Aix Set to in Sprid | DUE TO (OR DUE TO COR d. DUE TO COR d. DUE TO COR DUE TO COR d. DUE TO COR DU | AS A CONSE | equence of | not enter the | Ol Laus mode of dylng, | cens such ee | ST. B cerdiec or resp | alto. Iratory errest | 24b. WE AMM CO | Approximate Interval Between Onset and Death Onset and Death Real Price Property Findings (ILABLE PRICE TO F CAUSE |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

YEAR

3. TIME OF DEATH

REG. NO 2. DATE OF DEATH

STATE REGISTRAR

1. DECEDENT'S NAME (First Middle Last)

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12-9-90 Patrick Iannuantuono 10:29AM 7. DATE OF BIRTH (Month, Day, Year) 2 - 17 - 35 A SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. MARYLAND 1 X M 2 | F 55 YRS. 218-30-6182 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWH OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Johns Hopkins Hospital Baltimore City RESIDENCE OF DECEDENT 10d. INSIDE CITY 10c CITY TOWN OR LOCATION 10a STATE 105 COUNTY BALTIMORE 1 YES 2 NO MARYLAND 100 STREET AND NUMBER 10g, CITIZEN OF WHAT COUNTRY? FUNERAL 10f ZIP CODE 21231 USA 249 S. ANN STREET funeral director, page 5 should be detached for use as the burial-transit 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Marrie IF YES, GIVE WAR OR DATES Specify BY 3 Widowed 4 Divorced WHITE ETED 16s. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Sp Elementary/Secondary (0-12) College (1-4 or 5+) CONSTRUCTION COMPL MASON YEARS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surneme, LENA COFLICE Ħ FRANK IANNANTUONO BE notified 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. INFORMANT'S NAME (Type/Print) 2 249 IRS. BONNIE IANNANTUONO ANN STREET BALTO, MD. 21231 Pe 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 20a, METHOD OF DISPOSITION
1 Buriel 2 Cremation 3 Removal from State must HOLLY HILLS CEMETERY MARYLAND 4 Donation 5 Other (Specify) T. SIGNATURE OF FUNERAL SERVICE LICENSEE examiner KACZOROWSKI FUNERAL HOME 2525 FLEET STREET BALTO. MD. the medicai es, or complications that caused the deeth. Do not enter the mode of dying, auch ea cardlec or reepiratory errest, 23. PART I. Enter the disee filled in by shock, or heart fallure. List only one cause on each line Interval Between 5 **Onset and Death** IMMEDIATE CAUSE (Final completely filled irial, cremation, o the disease or condition Subarachnoid hemorrhage resulting in death) event. DUE TO (OR AS A CONSEQUENCE OF): burial, traumatic CERTIFICATION and Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF). prior to t if eny, leading to immediate physician cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events other DUE TO (OR AS A CONSEQUENCE OF): the attending p reaulting in death) LAST 0 injury, PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? signed by the that shows any 1XXXYES 2 NO XX YES 2 NO has been : Dept. of h PHYSICIAN: AW. 23 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) The Hem State certificate HOSPITAL OTHER:
4 Nursing Home 5 Residence 8 Other (Specify) XXXXES 2 - NO tlent 2 - ER/Outpatient 3 - DOA the 0 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED marked, with this XX Natural 5 Pending Investigation 1 YES 2 NO BY death 2 Accident ATTENDING After 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) .00 3 Suicide 8 Could not be COMPLETED DIRECTOR: / 28 4 Homicide Hem OR 29a. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) and menner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho HOSPITAL MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and menner as stated. 29b. SIGNATURE AND TITLE OF GERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12-10-90 OCME 2 38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A to reduce the work and a second DONALD WRIGHT, MD 111 Penn Street, Baltimore, MD 21201 VC



was the other

BALTIMORE, MARYLAND 21203-3146

2 Page 6 may be retained by 1 al director, page 5 should be Ħ be notified must examiner funeral after death. filled in by the found or removal. medical the cremation. completely executed within event, burlal, (other traumatic and Hydiene prior to physician requires that the death certificate be attending 0 signed by the atter Health and Mental Injury, 1 any l Health a Shows been of 1 certificate has be WE 23 He Item L DR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate 2 hours after death with the State 6 marked, 69 28 tem FUNERAL I HOSPITAL = TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

31. DATE PILED (Month, Day, Year)

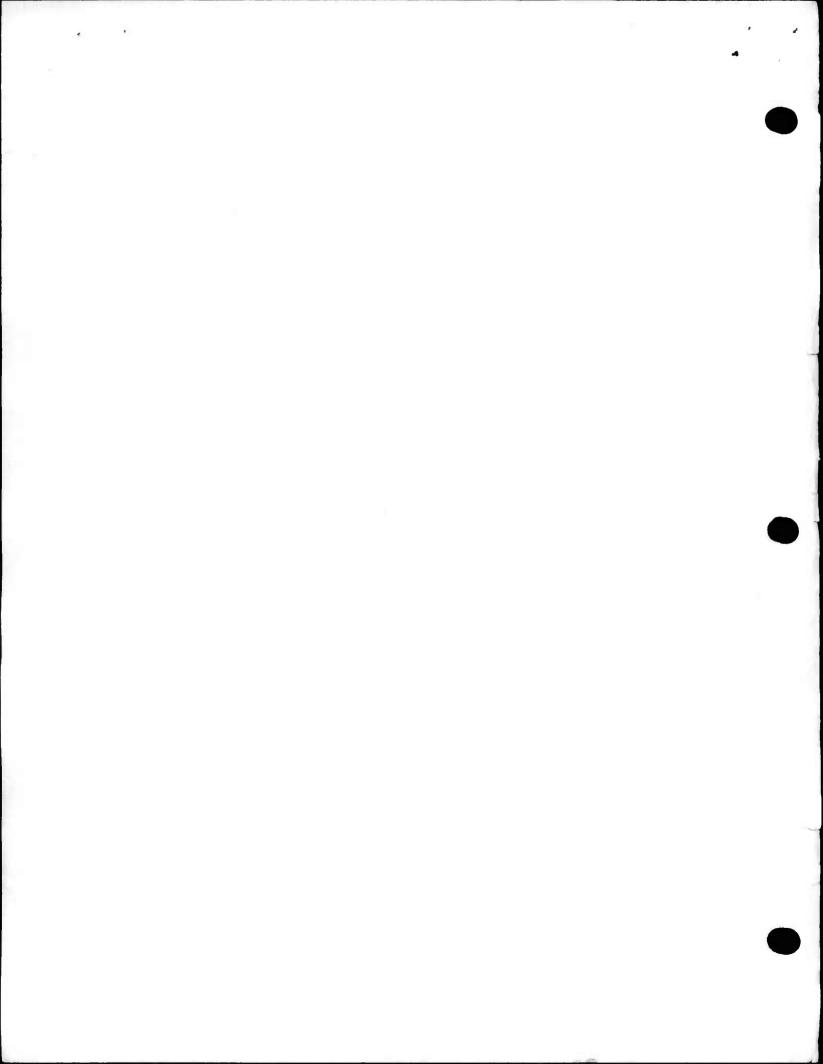
32. REGISTRAR'S SIGNATURE

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH JOHNSON SHIRLEY DAY YEAR 400 hirle-0 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 705-09-805 00 9e. FACILITY NAME (If not institution, give street 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Losephis Baltimore County ows RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Towson MD 1 U YES 2 NO Balto Co. 8720 Emgee Road FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 8720 Emgee Rd Meridan n/home USA 21234 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 If yes, specify Cubsn, Mexican, Puerto Ricen, etc.)

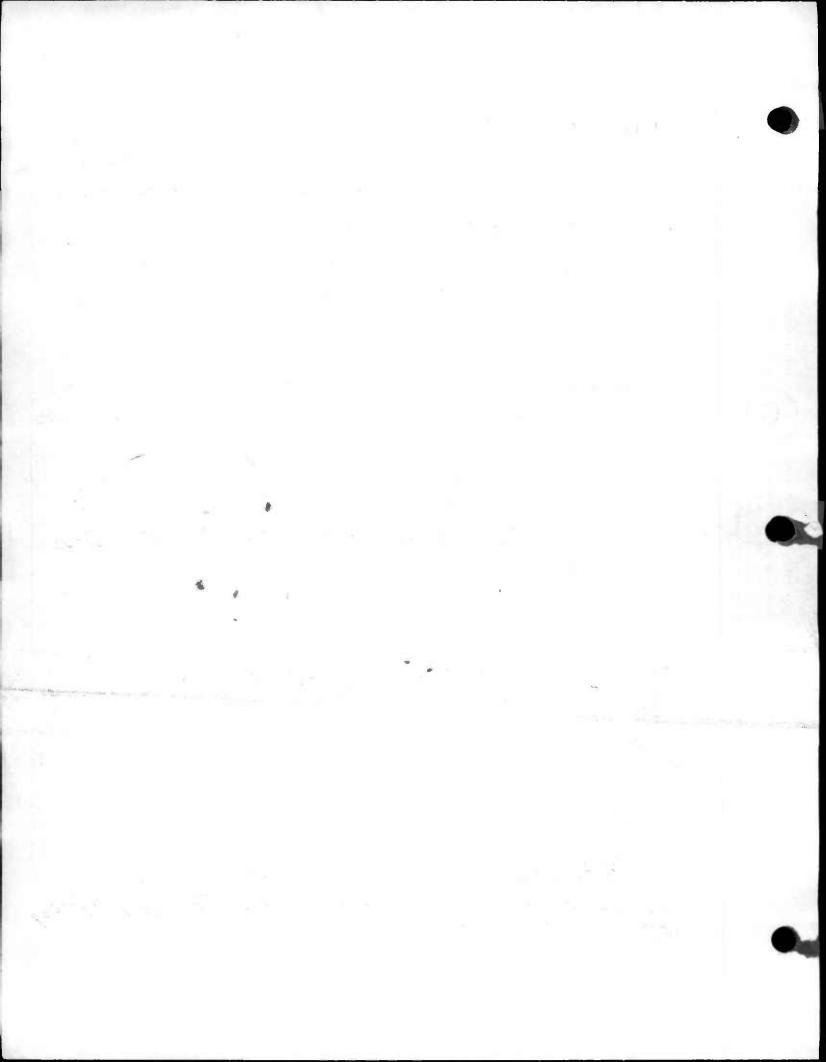
1 YES 2 NO Specify: 1 Never Married : 2 Merried Specify: BY 3 Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Malden Surname) BA 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code). 2 HARVEY LEVINE Guardian 8700 Old Harford Rd, Balto, MD 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion & Other (Specify) In state WADE, DIR 22. NAME AND ADDRESS OF FACILITY WICE LICENSEE RONALD STATE ANATOMY BOARD nanc 655 W. Balto St, Balto., MD 21201 23. PART I. Enter the diseases, of complications that ceused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximeta shock, or heart fallura. List only one cause on each line. Interval Between Onset and Death **IMMEDIATE CAUSE (Finel** diseasa or condition_ a. DUE TO (OR AS A CONSEQUENCE OF): resulting in death) 0 CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initiated evants resulting in death) LAST PART ii. Other algorificant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24b. WERE AUTOPSY FINDINGS 24a. WAS AN AUTOPSY MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 YES WO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL: OTHER: 1 YES THE 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED Natural М 1 YES 2 NO B Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, 3 Suicide COMPLETED 8 Could not be 4 🗌 Homicide 29e. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner es atsited. MA SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month: Day, Year) BE 2 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOSEBYZ al ravaliv m



| | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
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| examiner must be no | IMPORTANT I See a marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be no |
| he funeral director or 5 al. | ID THE PARTICLE STATES AND THIS CAPITICATE has been signed by the attending physician and completely filled in by the funeral directions in their many and are state Dept. of Health and Mental Hygiere prior to burial, cremation, or removal. |
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| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
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| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH MONTH DAY YEAR 3. TIME OF OEATH | | | | | | | | | |
| | LIDA MARY JOHNSON 12- 9 4-10 9 4-10 | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 6. AGE (In yrs. lest birthdey) 96 YRS. 97 | | | | | | | | | |
| | 9e. FACILITY NAME (if not institution, give street end gumber) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | |
| DIRECTOR | PRESBYTERIAN HOME OF MD TOWSON BALTIMONE | | | | | | | | | |
| E | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 YES 2 \(\text{NO} \) 10 WS ON | | | | | | | | | |
| LD | 1 USON 1 USES UNO 106. STREET AND NUMBER 101. ZIP CODE 109. CITIZEN OF WAAT COUNTRY? | | | | | | | | | |
| BY FUNERAL | 400 GEORGIA COUNT 21204 UIS | | | | | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 1 Never Merried 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— if yes, specify Cuban, Mexican, Puerio Rican, atc.) 14. RACE — American Indian, Biack, White, atc. | | | | | | | | | |
| | 3 Mildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 NO Specify: Specify: | | | | | | | | | |
| 9 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working) 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | |
| COMPLETED | Elemantary/Secondary (0-12) College (1-4 or 5+) Ilfe. Do NOT use retired.) | | | | | | | | | |
| OME | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | | | | |
| BE C | WILLIAM BELL ALICE LEWIS (BOLL) | | | | | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | |
| F | MRS KOBERT SHAW 56 LINDEN AVE WESTBROOK CONVOGSAS | | | | | | | | | |
| | 20s. METNOO OF OISPOSITION 1 Suriel 2 Cremation 3 Removal from State 1 Disposition 5 Other (Specify) | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald Wade, Dir 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD | | | | | | | | | |
| | 655 W. Balto St, Balto, MD 21201 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart feliure. List only one cause on sech line. | | | | | | | | | |
| | Onset and Daeth | | | | | | | | | |
| | disease or condition | | | | | | | | | |
| _ | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | |
| CA | CAUSE (Disease or Injury | | | | | | | | | |
| | that initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | | | | | |
| 병 | d | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY PHOINGS AMALABLE PRIOR TO AMALABLE PRIOR TO | | | | | | | | | |
| EDICAL | HSCVD - CHRONIC HIRIAL FIBRILLATION 1 - YES 2 1/2 NO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | |
| Σ | 1 YES 2 NO | | | | | | | | | |
| NA N | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check cold cond.) | | | | | | | | | |
| PHYSICIAN: | EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| Ť | 27. MANNER OF DEATH 28a. DATE OF INJURY 29b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | |
| BY P | 1 Netural 5 Pending 2 Accident Investigation (Month, Day, Year) INJURY WORK? M 1 YES 2 NO | | | | | | | | | |
| | 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, attc. (Specify) Circ Term, Shrip Could not be building, attc. (Specify) Circ Term, Shrip Circ Term, Shrip Circ Term, Shrip | | | | | | | | | |
| domplered | 4 Homicide determined | | | | | | | | | |
| MPL | 29s. CERTIFIER (Check only one) APPLICAL EXAMPLE. On the best of my knowledge, death occurred at the time, date and piece, end due to the cause(e) end manner as stated. | | | | | | | | | |
| -8 | 2 MEDICAL EXAMINER: On the basis of azamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. | | | | | | | | | |
| BE | 296. SIGNATURE AND INTERPRETATION DAY, Year) 296. LICENSE NUMBER 296. LICENSE NUMBER 296. DATE SIGNED (Month, Day, Year) 1297. 100 240 1297. 100 240 | | | | | | | | | |
| 0 | 30. NAME AND ADDRESS OF PERSON WNO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S. J. VENABLE M.D. 610 WILTON ROAD TOWSON MD 2120. 31. DATE FILED (MORELY, DRV. ABRU) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | 31. DATE FILED (Mouth, Day, John) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | DECL 21990 Silver Sundam Andrew | | | | | | | | | |
| | · · · · · · · · · · · · · · · · · · · | | | | | | | | | |



| BALTIMORE, MARYLAND | 711 | (defacthe | at once. |
|--|--|--|---|
| MAR | be regained | De 5 should | e notified |
| AORE, | ge 6 may | firector, pa | r must b |
| 3ALTIN | r death. Pa | ne funeral cal. | examine |
| | Surs afte | led in by th | medical |
| 46, | d within 2 | ompletely fill cremation | event, the |
| X 131 | be execute | ician and co | raumatic |
| .O. BC | h certificate | nding physi- | or other t |
| RDS, P | at the death | by the atte | y injury. |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | requires th | een signed of Health | shows an |
| 'ITAL | N: The law | State Dept | Item 23 |
| I OF V | 3 PHYSICIA | er this certi | arked, or |
| ISION | ATTENDING | CTOR: After | 1 28 is m |
| 10 | PITAL DR | ERAL DIRE | T: If item |
| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 ways after death. Page 6 may be regained by the control of the con | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should in the state Debt. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It iem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

¥203-3146

| | REGISTRAR | ND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT | | | | | | | |
|--|--|---|--|--|--|--|-----|---|-------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) Marie Dela | nes Jordan | | DAY YEAR 2:// PM | | | | | |
| | | yrs. last birthday) IF UNDER t YEAR IF UNDER | | 6. BIRTHPLACE (State or Foreign | | | | | |
| | 219-05-8672 10M2 XF 8 | | MIN. (Month, Day, Year) | Country) MJ | | | | | |
| | So FACILITY NAME (II not institution the street and number) | DE CITY TOWN OR LOCATE | ON OF DEATH | 9c, COUNTY OF DEATH | | | | | |
| OB | Francis Scott Key Medical | center Baltimo, | e, MD | > | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10d. INSIDE CITY LIMITS? | | | | | | |
| | MD | Baltimore | | 1 🔀 YES 2 🗌 NO | | | | | |
| FUNERAL | 100. STREET AND NUMBER 606 Tolua ST. | 10f. ZIP CODI | of zip code $2(224)$ 0 10g. Citizen of what country? $0 \le A$ | | | | | | |
| SNO | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U | J.S. ARMED 13. WAS DECENDENT O | OF HISPANIC ORIGIN? (Specify Y | fee or No— 14. RACE — American Indian, Black, White, etc. | | | | | |
| BY F | 1 Never Merried 2 Merried FORCES? 1 YES IF YES, GIVE WAR OR DAT | | n, Mexican, Puerto Rican, etc.) Specify: | Specify: White | | | | | |
| | 15, DECEDENT'S EDUCATION | IRe. DECEDENT'S USUAL OCCUPATION | | 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) | (Give kind of work done during most of workle life. Do NOT use retired.) | | | | | | | |
| MPL | 8 | Housework | At Hon | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) Louis Lewandowski | | HER'S NAME (First, Middle, Maide | and the same of th | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number | therine Kuzn | | | | | | |
| 2 | John W. Jordan | 606 S. Tolna St | reet Balto Md. | . 21224 | | | | | |
| | 20e. METHOD OF DISPOSITION 1X Burlel 2 □ Cremetion 3 □ Removal from Stete 4 □ Donetion 5 □ Other (Specify) | PLACE OF DISPOSITION (Name of cometery, cremother place) Oak Lown (eme: | teru & | astuood, Md. | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler & Son Inc. Eastern Charles S. Zeiler & Son Inc. Eastern | | | | | | | | |
| | ▶ Charle D. Jete | (harles S. | Zeiler & Son | Inc. Eastern Ave. | | | | | |
| | 23. PART I. Entar tha diseases, or complications that caused shock, or heart failure. List only one cause on as | | ing, such as cardiac or rea | intarvai Batween | | | | | |
| | iMMEDIATE CAUSE (Final disease or condition | | | Onset and Daath | | | | | |
| | disease or condition a. Sepsis Due to (on as Appenseouence of): | | | | | | | | |
| z | Romal bouling. | | | | | | | | |
| CERTIFICATION | it any, leading to immediate | , | | | | | | | |
| FIC | cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A) | 25 cuby accident | | | | | | | |
| FE | that initiated events resulting in daath) LAST | | | | | | | | |
| | PART II. Other aignificant conditions contributing to death but | t not resulting in the underlying cause | given in Part i 24e MAS | AN AUTOPSY 24b, WERE AUTOPSY FINDINGS | | | | | |
| SE | Renal Failure, Stro | PERF | ORMED? AVAILABLE PRIOR TO | | | | | | |
| ED | | 1- 1 | I _ J YES | 2 OF NO OF DEATH? | | | | | |
| ž | | | | | | | | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF 0 | DEATH (Check only one) | | | | | | |
| YSI | 1 TYES 2 NO 1 TA Inpatient 2 ER/Outpa | tient 3 DOA 4 Nursing Home 5 R | seldence 8 - Other (Specify) | | | | | | |
| H | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 1 № Natural 5 Pending | 28b. TIME OF 28c. INJURY AT WORK? M 1 YES 2 | | W INJURY OCCURED | | | | | |
| Action Comparison Compari | | | | | | | | | |
| | | | | | | | PLE | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge) | menner es atated. |
| Ö | one) 2 MEDICAL EXAMINER: On the basis of examination | end due to the cause(s) and manner as stated. | | | | | | | |
| BE C | 291- SIGNATURE AND TITLE OF CERTIFIER | 1) ()) | | | | | | | |
| 6 | | | | | | | | | |
| | ST PERSON PRO COMPLETED CAUSE OF GEN | (Land L.) Links | | | | | | | |
| | 31. DATE FILEO (Month, Day, Year) 32. REGISTRAR'S SIGNA | | | | | | | | |
| | DEC 12 1990 Julia Davidson | Manual | | DHMH 16 Pay +/90 | | | | | |

DHMH-16 Rev t/89

431 Y X X A LONG TO THE RESERVE and the second s AND THE RESERVE OF THE PARTY OF

be notified at once.

BALTIMORE, WARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE 2 Sequentielly list conditions,

If any, leading to immediate cause. Enter UNDERLYING

CAUSE (Disease or injury

that initiated events resulting in death) LAST

| | | | | | | | | | | | 70 | 9 | 410 | U |
|---|--|--------------|--|--|--|--------------------------------------|-----------------------------|---|-------------------|---------|--------------------------------------|--------|------------------|---|
| | FOR STATE REGISTRAR | STATE OF MAR | | | | | EALTH AND I | | YGIENI EG. NO. | E | | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | Evelyn V. | Johns | son | | | | 2. DATE OF I | DEATH DA | 199 | year 90 | 3. TIM | E OF DEATH | м |
| BE COMPLETED BY FUNERAL DIRECTOR | 4. SOCIAL SECURITY NUMBER 217-16-1233 | 5. SEX 8. A | GE (In yrs. les 74 | t birthday) YRS. | IF UNDER 1 | YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF 8 (Month, Da | 191 | 6 | 8. BIRTI- Counti | | (State or Foreig | n |
| | 9a. FACILITY NAME (If not institution, give street and number) 3800 W. Belvedere Avenue | | | | 96. COUNTY OF DEATH Baltimore | | | | | | | | | |
| | 10a. STATE 10b. COUNTY | | | city, town or Location altimore | | | | | | | 10d. INSIDE CITYLIMITS? 1 YES 2 NO | | | |
| | 3800 W. Belvedere Avenue | | | | | | | ZEN OF WHAT COUNTRY? USA | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify, Cuban, Maxican, Puerto Rican, etc.) 1 VES 2/1/NO Specify: 14. RACE — American Intelligence, White, etc. Specify: Black | | | | | ı, atc. | | | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (G. | 16e. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of wo life. Do NOT use retired.) Domestic Work | | | N st of working | 166. KIND OF BUSINESS/INDUSTRY | | | | | | |
| | The state of the s | | | | | IAME (First, Middle, Maiden Surname) | | | | | | | | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) HAZEL TILLMAN | | 196. MAILING ADDRESS (Street and Number or Rural 4310 Pimlico Road | | | Baltimore, Md 21215 | | | | | | | | |
| | 1A Buriel 2 Cremetion 3 Removel from State (ther place) | | | osition (Name of cametery, crematory or udon Park Cemetery | | | y Baltimore, Md | | | ate | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | 22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that coused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) DUE TO IOR AS A CONSEQUENCE OF: | | | | | | | | Approximate interval Batt Onsat snd D | waan | | | | | |

COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) OTHER 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA Home 5 Nesidence 8 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, ferm, street, factory, office building, atc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

8 Could not be determined 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2120

296. SUMATURE AND TITLE OF CONTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) lac

31. DATE FILED (Month, Day, Year)
DEC 1 2 1990 32. REGISTRAR'S SIGNATURE

Davidson Januare

DUE TO (OR AS A CONSEQUENCE OF):

OUE TO (OR AS A CONSEQUENCE OF):

su hue

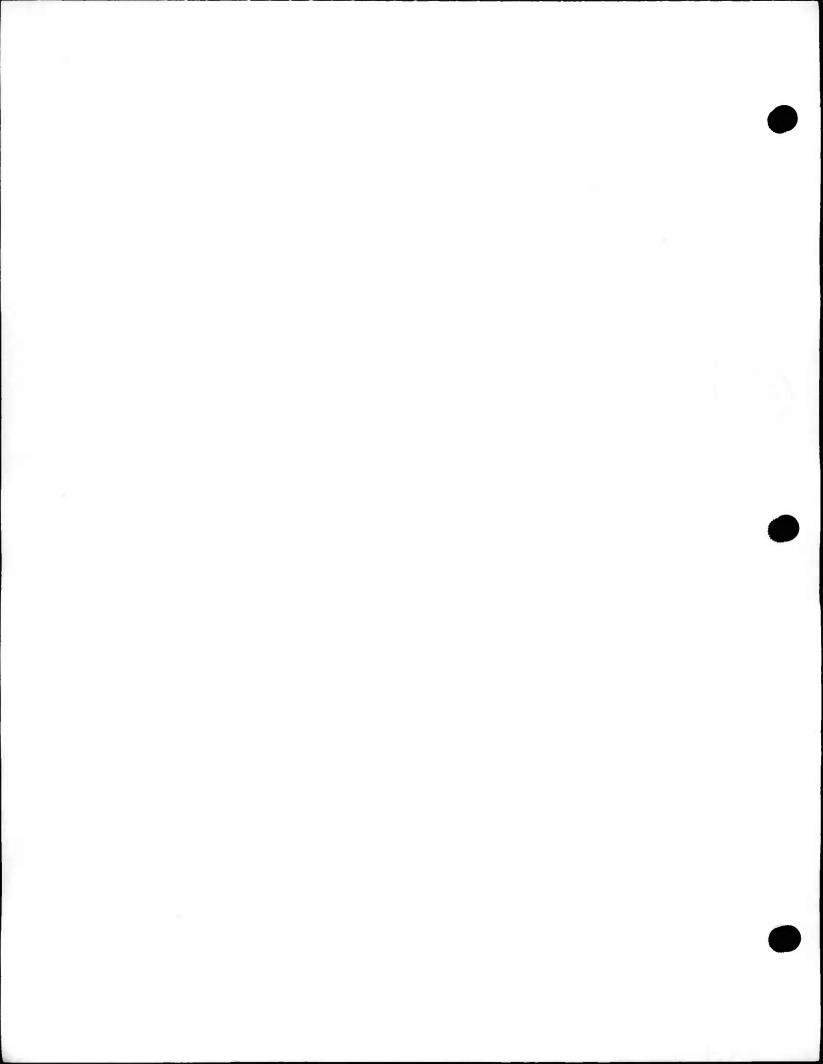
PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I.

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO

24a. WAS AN AUTOPSY

1 YES 2 NO

PERFORMED?



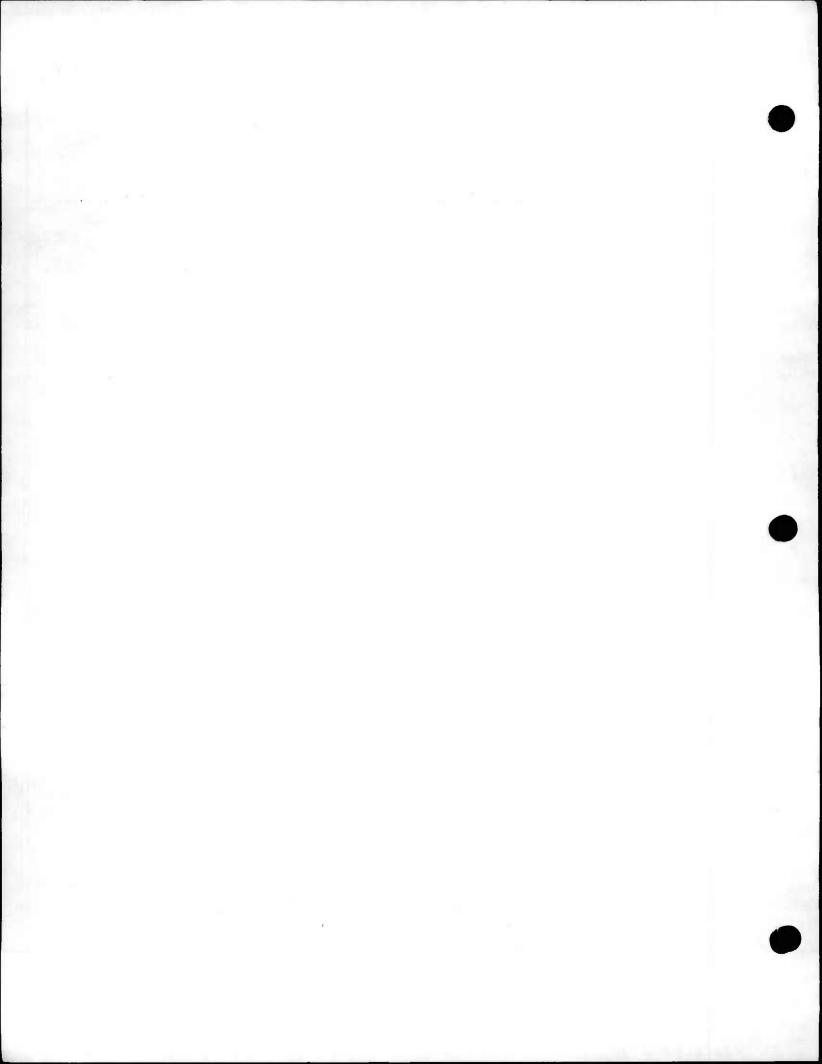
DHMH-16 Rev 1/89

menficate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

ad, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 見り | BETORY | See of | 7244 |
|---|-------------|---------------|----------------|--------------|
| 9 | IOSPITAL OF | E FUNERAL DIR | rithin 72 hour | ANT: If Item |
| | TO THE | TO THE F | be filed v | IMPORTANT |
| | | | | |

| | FOR STATE REGISTRAR | STATE OF MARYLAND C | / DEPAR | | | | | MENTAL HYGIENE REG. NO. | | 0 04105 |
|----------------------|---|--|---|--------------------------|-------------|--------------------------|-----------|---|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Leat) JAMES H | | K | EARNI | EY | | | 2. DATE OF DEATH DAY 12 08 | | |
| | 244-15-7890A ¹ | SEX 6. AGE (In yrs. II | last birthday) YRS. | IF UNDER MONTHS | DAYS | IF UNDER 2 | MIN. | 7. DATE OF BIRTH (Month, Day, Year) 7 - 24 - 20 | a | NTHPLACE (State or Foreign N.C. |
| TOR | 99. FACILITY NAME (If not institution, give street NORTH ARUNDEL HOSF RESIDENCE OF DECEDENT | | 'ION | | | BURN | | ATH | A . | A. COUNTY |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | y, town o | | ION | | | II. | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 445 QUEENSTOWNE | RD. | | | 101 | 211 | | | | S A |
| B≺ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | :. WAS DECEOENT EVER IN U.S. A FORCES? 1/2 YES 2 I IF YES, GIVE WAR OR DATES | NO | 10 | yes, sp | | , Mexicar | IC ORIGIN? (Specify Yee n, Puerto Rican, etc.) | | BLACK |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) 7 t n | npleted) | DECEDENT'S (Give kind of life. Do NOT u | work done o | CCUPATIO | ON st of working | 7 | 166. KIND OF BUS | STEEL | Y I |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) RICHARD KEARNE | Υ | | | | | | LA BRADL | | ARNEY |
| 70 | 190. INFORMANT'S NAME (Type/Print) ANNIE B. KEARN | EY | 445 | QUEE | NST | OWNE | RE | Oute Number, City or Town O SEVERN | | |
| | 20e. METHOD OF DISPOSITION 1 & Burlel 2 Cremation 3 4 Doneton 5 Other (Specify) | W 00 | DLAW | N CE | MET | ERY | | WOO | DLAWN | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE OPEN | ad | | | | o addres | | | 01 E. | NORTH AVE. |
| | 23. PART I. Enter the diseases, or com- ahock, or heart feliure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) a | t only one cause on each ile | na. | 0 | | | | as cardiac or reapi | | Approximata interval Batwean Onset and Death |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | OUE TO (OR AS A CONS | SEQUENCE C | PF): | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | DUE TO (OR AS A CONS | SEQUENCE O | OF}: | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other aignificant conditions of | | _ | | | _ | iven in | Part I. 24a. WAS AN PERFOR 1 TYES 2 | MED? | /24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIA | | IOSPITAL: Inpetient 2 - ER/Outpatient | 3 🗆 DOA | OTHER | ₹: | | | 6 Other (Specify) | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 26s. DATE OF INJURY (Month, Day, Year) | - 12 | M | 1 🗆 | JURY AT ORK? YES 2 |] NO | 28d. OEŞCRIBE HOW II | | |
| | 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — At building, etc. (Specify) | home, farm, | street, fact | tory, offic | :• | | 28f. LOCATION (Street e City or Town, State) | and Number or R | ural Route Number, |
| COMPLETED | one) | N: To the best of my knowledge, On the basis of examination and/ | | | | | | | | use(e) and manner as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF PERTIFIER | Rell " | 10) | | | 29c. LICE | NSE NUI | ABER . | 29d. DATE SIG | NEO (Month, Day, Year) |
| ۴ | | M.D./1600 CRA | IN HI | e, <i>Prine)</i> GHWA | Y, S | W #30 | 02/G | LEN BURNIE | <u>, MD</u> | 21061 |
| | DEC 1 2 1990 | 32. REGISTRAR'S SIGNATURE | Pande | De. | | | | | | |

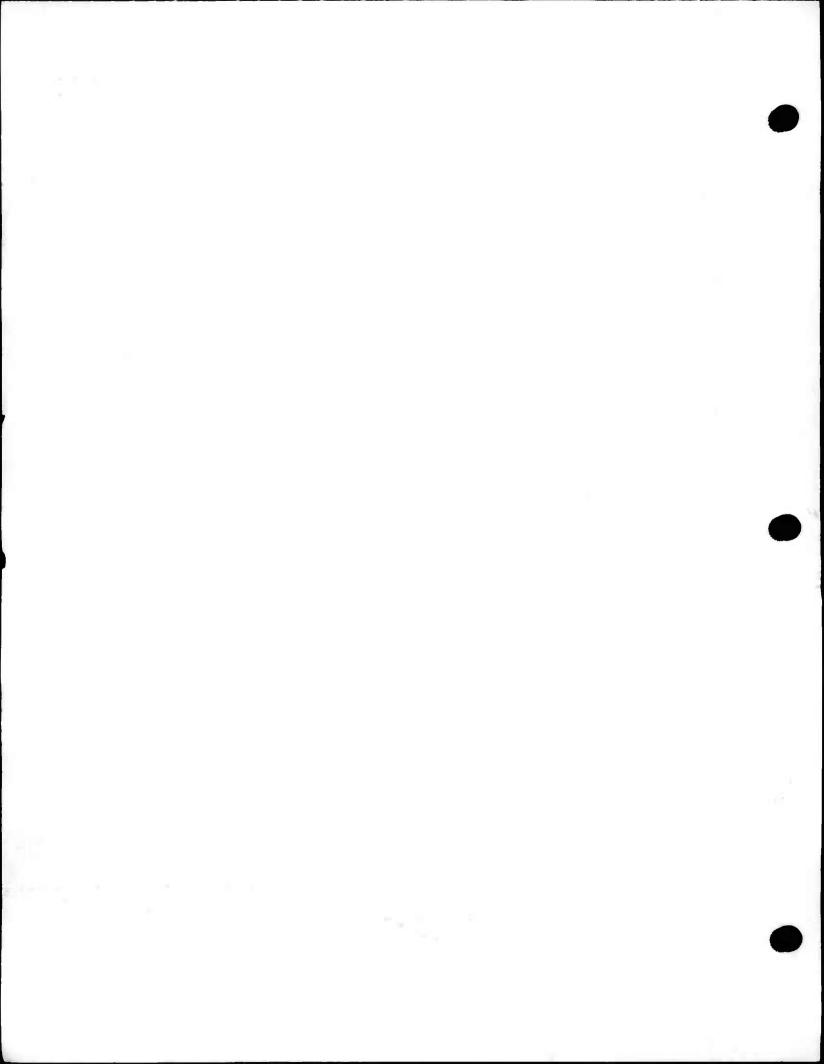


| | once. | |
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| or remova | t, the medical | |
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| | 1 - FOR STATE REGISTRAR | STATE OF MAR | | RTMENT OF H | | MENTAL HYGIEN REG. NO. | - | 0 34110 |
|------------------------------------|--|--|---|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 2 1/5 | | | | 2. DATE OF DEATH MONTH DA | V . YE | 3. TIME OF DEATH |
| | | DG. KEI | | | | 12 | 9 90 | 7:10 PM |
| | 4. SOCIAL SECURITY NUMBER 41434-4592 | 5. SEX 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | AGE (In yrs. last birthda) 58 YRS. | | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 12/10/3 | | SIRTHPLACE (State or Foreign Country) Country) |
| _ | 9a. FACILITY NAME (If not institution, give s | | | 9b. CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY | OF DEATH |
| CTOR | GOOD SAMAR | | OSPITAL | BALT | IMOR | <u>E</u> | BAL | imort |
| E | 10e. STATE 10b. COUNTY | | | HTY, TOWN OR LOCAL | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Balt | timore | | Perry Ha | I I | | 100 CITIZEN | 1 YES 2 NO |
| FUNERAL DIRECTOR | 6 Durban Court | Apt C | | | 21236 | | U.S. | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 X Xerried 3 Nidowed 4 Divorced | 12. WAS DECEOENT EV FORCES? 1 [X] IF YES, GIVE WAR KOYEAN & V | OR DATES | If yes, ap | CENDENT OF HISPAN ecity Cuben, Mexice 2 (X NO Specify | IIC ORIGIN? (Specify Yee n, Pueno Ricen, atc.) /: | | RACE — American Indien, Black, Whita, atc. Specify: Ihite |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | completed) | 18e. DECEDENT (Give kind a life. Do NOT | of work done during mo | ON ost of working | 16b. KIND OF BU | | |
| 2 | Elamentary/Secondary (0-12) | College (1-4 or 5+) | Compute | er Techni | cian | | | |
| NO. | 17. FATHER'S NAME (First, Middle, Lest) | | 100500 | | 1 | ME (First, Middle, Maiden | Surname) | |
| BEC | Charles I. Ke | ifer | | | Ruth | Wilmarth | | |
| 10 | 19a, INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | , |
| | Ruth Amy Jednors | <u><i< u=""></i<></u> | | | | to., Md. 2 | | |
| | 20e. METHOD OF DISPOSITION 1 | oval from Stata | other place) GreenMount | osition (Name of co. t Cemetery | metery, crematory or | | to., Md. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE ROY H. Cather | | | | ND ADDRESS OF FA | CILITY | | |
| | Rou H. C. | | | Leonard | d J. Ruck,I | nc.,5305 Har | ford Rd. | ,Balto.,Md. 21214 |
| | 23. PART I. Enter the diseasea, or ahock, or heart failura. | complications that ca | nused the deeth. Do | o not antar the mo | ode of dying, auc | h aa cerdlec or reep | iratory arreat | Approximate interval Between |
| - 1 | IMMEDIATE CAUSE (Fine) | A. W. 1911 | | | | | | Onset and Death |
| | disease or condition resulting in death) | a. PULM DUE TO (OR | ONARY | 1 DMB | OLISM | | | 12 his |
| | | DUE TO (OR | VEIN | TUD MA | RACIC | | | 2 days |
| ō | Sequentially list conditions, if any, leading to immediate | DUE TO (OR | AS A CONSEQUENCE | OF): | ~00/0 | | | 1.00394 |
| CA | cause. Entar UNDERLYING CAUSE (Disease or Injury | | | | | | | |
| TF | | C | | | | | | |
| | that initiated events | C. DUE TO (OR | AS A CONSEQUENCE | OF): | | | | |
| CER | that initiated events resulting in deeth) LAST | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | |
| AL CERTIFICATION | PART II. Other algorificant condition | d | ath but not reaultin | | ig ceuse given in | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| CAL | PART II. Other algorificent condition | dna contributing to da | ath but not resultin | | ig ceuse given in | Part I. 24a. WAS AMPERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | PART II. Other algorificant condition | dna contributing to da | ath but not resultin | | ng ceuse given in | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY | dna contributing to da | ath but not resultin | ig in the underlyin | | PERFOI | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | d. H YPERTE H FIBR HOSPITAL: | ath but not resulting | og in the underlyin | LACE OF DEATH (Ch | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL | d. H YPERTE H FIBR HOSPITAL: | ath but not resulting TVS10W | 25. P OTHER: A 4 Nursing Hor | LACE OF DEATH (Ch | PERFOI 1 YES : | RMED? ⊇ ⊠ NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |
| PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Matural 5 Pending | d | ath but not resulting NSION | 26. P OTHER: A OTHER: A OTH | LACE OF DEATH (Ch | PERFO | RMED? ⊇ ⊠ NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |
| BY PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | HOSPITAL: 1 Vinpstlent 2 EP 28e. DATE OF INL 28e. PLACE OF IN | ath but not resulting SIGN OSIS R/Outpatient 3 DO/ 1007 28b. | 26. P A OTHER: A Unvising Hor TIME OF UNUSING HOR INJURY M 1 | LACE OF DEATH (Ch | PERFO 1 YES : 1 YES : 1 YES : 2 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street | INJURY OCCUR | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 ▼ NO |
| BY PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | d | ath but not resulting SIGN OSIS R/Outpatient 3 DO/ 1007 28b. | 26. P A OTHER: A Unvising Hor TIME OF UNUSING HOR INJURY M 1 | LACE OF DEATH (Ch | PERFOI 1 YES : neck only one) 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 ▼ NO |
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| COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | d | ath but not resulting TVSI (V) OSIS R/Outpatient 3 DOA JURY 28b. JURY 4th home, fam. (Specify) | 26. P A 4 Nursing Hor TIME OF 28c. IN W 1 | LACE OF DEATH (Ch me 5 Residence JURY AT ORK? YES 2 NO ce | PERFO 1 YES : 1 YES : 2 Other (Specify) 2 Ed. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the cause(e) end ma time, date end place, e | end Number or | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RUTAL Route Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | d | ath but not resulting TVSI (V) OSIS R/Outpatient 3 DOA JURY 28b. JURY 4th home, fam. (Specify) | 26. P A 4 Nursing Hor TIME OF 28c. IN W 1 | LACE OF DEATH (Ch me 5 Reeldence JURY AT ORK? YES 2 NO ce a end placa, and due death occured at the | PERFO 1 YES : 1 YES : 2 Other (Specify) 2 Ed. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the cause(e) end ma time, date end place, e | end Number or | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, |
| E COMPLETED BY PHYSICIAN: MEDICAL | PART II. Other algnificent condition PULMONARY PULMONARY PULMONARY 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | d | R/Outpatient 3 DO/ DIURY At home, fam. (Specify) Rhowledge, death occulnation end/or investig | 26. P A 4 Nursing Hor TIME OF 28c. IN W I III m, street, factory, office of the letton, in my opinion, when the letton, in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion, when the letton is the letton in my opinion is the letton in my opinion. | LACE OF DEATH (Ch | PERFO 1 YES : 1 YES : 2 Other (Specify) 2 Ed. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the cause(e) end ma time, date end place, e | end Number or nner ee stated. 2 9d. DATE S | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, ause(e) and manner ee stated. GNED (Month, Day, Year) |

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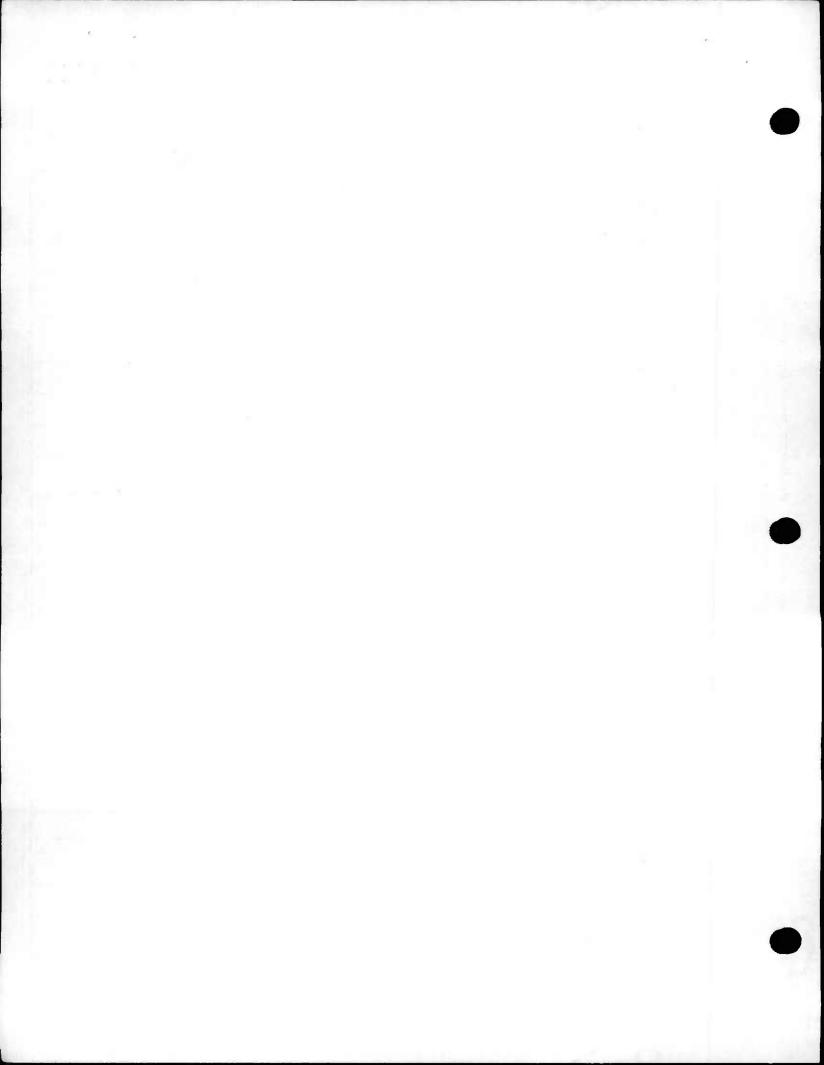
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| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|
| e funeral director, page 5 should be detached al. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Heath and Mental Hyglene prior to burial, cremation, or removal. |
| death. Page 6 may be retained by the hospi | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospi |

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. |
|---------------------------|---|-------------------------------|
| MARY S. LOUDEN | | 2. DATE OF DEATH MONTH DAY |

| | 1. DECEDENT'S NAME (First, Middle, Last) MARY S. LOUDEN | | | | 2. DATE OF DEATH MONTH DA | -90 YEAR | 3. TIME OF DEATH | |
|-----------------------|--|--|--------------------------------|--|--|-----------------------------|--|--|
| | 218-14-7317 1 M 2 D 4 8. | (In yrs. lest birthday) 3 YRS. | IF UNDER 1 YEAR MONTHS DAYS | | June 1,1907 8. BHTTHPLACE (State or Foreign Country) VIRGINIA | | | |
| OR | 9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL BALTIMO: | | | | EATH | 9c. COUNTY OF | F DEATH | |
| FUNERAL DIRECTOR | MARYLAND | | TOWN OR LOC | | | | 10d. INSIDE CITY LIMITS? 1 1 YES 2 1 NO | |
| ERAL | 3630 KENYON AVENUE | | | 101. ZIP CODE 2121: | 3 | U. S | • A. | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVEN FORCES? 1 YES | 2 \(\overline{\text{NO}} \) | If yes, | ECENDENT OF HISPAI apacify Cuben, Mexica ES 2 NO Specifi | | Bi | ACE — American Indian, lack, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA | 16a. DECEDENT'S to (Give kind of we life. Do NOT use HOMEM. | ork done during retired.) | | 166. KIND OF BUS | HOME | , | |
| BE CON | 17. FATHER'S NAME (First, Middle, Lest) UNKNOWN | | | | ME (First, Middle, Meiden : UNKNOWN | Surname) | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) BETTY REEDY (DAUGHTER) | | | | Route Number, City or Town | | | |
| | 1XXSurial 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | ph. PLACE OF DISPOSE other place) PARKWOO! | D CEME | ERY | E | CATION — CHY OF BALTIMOI | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | SCH | AND ADDRESS OF FA IMUNEK FUI BREHMS 1 | CILITY NERAL HOMES LANE, BALTI | , INC. | MD. 21213 | |
| MEDICAL CERTIFICATION | Sequentieity list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE. Disease or Injury. | A CONSEQUENCE OF |): ; + C | | | | Interval Between Onset end Death | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given the conditions of the conditio | | | | PERFORMED? | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | |
| PHYSICIAN | 1 | tpatient 3 DOA 28b. TIME | OF 28c. | NJURY AT WORK? | 6 Other (Specify) 28d. DESCRIBE HOW II | NJURY OCCURED |) | |
| TED BY | Accident Newstration Investigation Inve | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination | | | | | | se(s) and manner as stated. | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER REALIZATION STORES | n 26 | 7 | 29c. LICENSE NU | мвея | ≥ / 2/9 | NED (Month, Day, Year) | |
| | 36. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF D F Dellon Z2 S Sneed 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIG | re St, 1 | Print) Salt, | mD: | 2120) | | | |
| | DEC 12 1990 Super Variables | andell | | | | | | |





| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 show the attending physician and completely filled in by the funeral director, page 5 show the | 1 | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| DR | 器 | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | lem. |
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| | FOR 1 - STATE | STATE OF M | ARYLAND / DE | | | IEALTH AND I DEATH | | | 34112 |
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| | REGISTRAR 1. DECEOENT'S NAME (First, Middle, Last) | | m Josep | | | | 2. DATE OF DEA | DAY YE | 3. TIME OF DEATH |
| ł | | _ | | | ruer | Lyout | 12 | | 0 1- AM |
| | 4. SOCIAL SÉCURITY NUMBER 218 - 12 - 4051 | 5. SEX | 8. AGE (In yrs. lest birl | thday) IF U | HS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRT (Month, Day, Y | egr) | BIRTHPLACE (State or Foreign Country) |
| | 9e. FACILITY NAME (If not institution, give str | | 66 | | CITY, TOWN | OR LOCATION OF DE | 2/2/ | 9c, COUNTY | Balt, more, mp |
| E | Francis Scott Ka | ey Mec | 1 Cente | 100 | Balt, | more | | fr. | |
| 5 | RESIDENCE OF DECEDENT 100. STATE 10b. COUNTY | / | | | WN OR LOCA | 77(01) | | | TALL MINIOS OFTEN |
| DIRECTOR | Maryland | - | | | mol | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | | f. ZIP CODE | | | OF WHAT COUNTRY? |
| FUNERAL | 1/28 Imla: | | | | | 2122 | T | | ited States |
| 5 | 11. MARITAL STATUS | FORCES? 1 | EVER IN U.S. ARMED |) | | CENDENT OF HISPAN Hecity Cuben, Mexico | | | RACE — American Indien, Black, White, atc. |
| | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE W | R OR DATES | 2 | | 2 XNO Specif | | | Specify: White |
| 60 | 15. DECEDENT'S EDUC | | ea , W.W. | ENT'S HSHA | L OCCUPATI | ON | 18h KIND (| OF BUSINESS/INDUS | |
| | (Specify only highest grade of Elementery/Secondary (0-12) | | (Give k | ind of work of NOT use retir | lone during med.) | ost of working | | | |
| COMPL | 12 | | Main | tenano | ce Mil | lright | Beti | rlehem St | eel |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | ME (First, Middle, I | Maiden Surname) | |
| BE | Joseph Lynch | | | | | Juli | ~ | | |
| 2 | 192. INFORMANT'S NAME (Type/Print) Eva Lynch | | 19b. M | 8 Im | la Str | eet Bald | Route Number, City | or Town, State, Zip Co 2/224 | ide) |
| | 20s METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | wal from State | 20b. PLACE OF other place) | Most | Holy | metery, cremetory or Redeemen | . 2 | Baltimon | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | ٨ | | 22. NAME A | ND ADDRESS OF FA | CILITY | | 6224 |
| | Dharle. | D. 3. | lu | | (har | les S. Ze | iler & S | Son Inc. | 6224 Eastern Ave. |
| | 23. PART I. Enter the diseases, or canock, or haert feiture. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one causes. | se on each line. | Jent | ocal | ode of dying, suc | hae cardiac or | respiratory arrest | t, Approximate Interval Between Onset and Death |
| z | Constant of the Hot constitution | Cons | OR AS A CONSEQUE | heo | rt | failu | re | | |
| RTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | |
| 2 | CAUSE (Diseese or Injury that Initiated events | DUE TO | OR AS A CONSEQUE | NCE OF): | | | | | |
| | resulting in death) LAST | ALIA | Din 31 | non | | | | | |
| 뜅 | | | | | | | | | |
| ¥ | PART II. Other significent condition | a contributing to | deeth but not resu | ilting in th | a underlylr | ng ceuae given in | | ERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| <u>ă</u> | DIVVIN | | | | | | 1 🗆 | YES 2 NO | OF DEATH? |
| ž | | | | | | | | | 1 TYES 2 NO |
| ž | 00 MMO 0105 DEFENDED TO MENTER. | | | | | | | | I |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | EDIO MANUEL A CI | | HER: | LACE OF DEATH (C) | | 1.1 | |
| £ | 27. MANNER OF DEATH | 1 Inpatient 2 28e. DATE OF | ER/Outpatient 3 INJURY 2 | 8b. TIME OF | | me 5 - Reeldence | | HOW INJURY OCCUI | PED |
| | 1 Natural 5 Pending | (Month, De | | INJURY | W | ORK? YES 2 NO | Lou. Degonise | now moon roots | 165 |
| 9 | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE OF | F INJURY — At home, | farm, street | , factory, offi | Ce | | (Street end Number or | Rural Route Number, |
| COMPLETED BY | 4 Homicide determined | building, | mtc. (Specify) | | | | City or Town | , State) | |
| ן ב | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of | eny knowledge, death | occurred at | the time, dat | e end place, end du | to the cause(e) a | ind manner ee stated. | |
| <u> </u> | deel only | | | | | | | | ceuse(e) end manner ea stated. |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 1 | | | ~ | 29c, LICENSE NU | | 29d. OATE S | NONED (Month, Day, Year) |
| 0 | I for ST | nje | M | | | D198 | 05 | ▶ 12 | 11/19 |
| f | 30. NAME AND ADDRESS OF PERSON WH | OCOMPLETED CAUS | E OF OEATH (ITEM 2 | 7) (Type, Print | 1) | | | | |
| | 31. DATE FILED (Month, Day, Year) | 990 FL | R'S SIGNATURE | -Randa | 99 | | | - | |
| - 1 | I CONTRACTOR S | 1 0 | | | | | | | |

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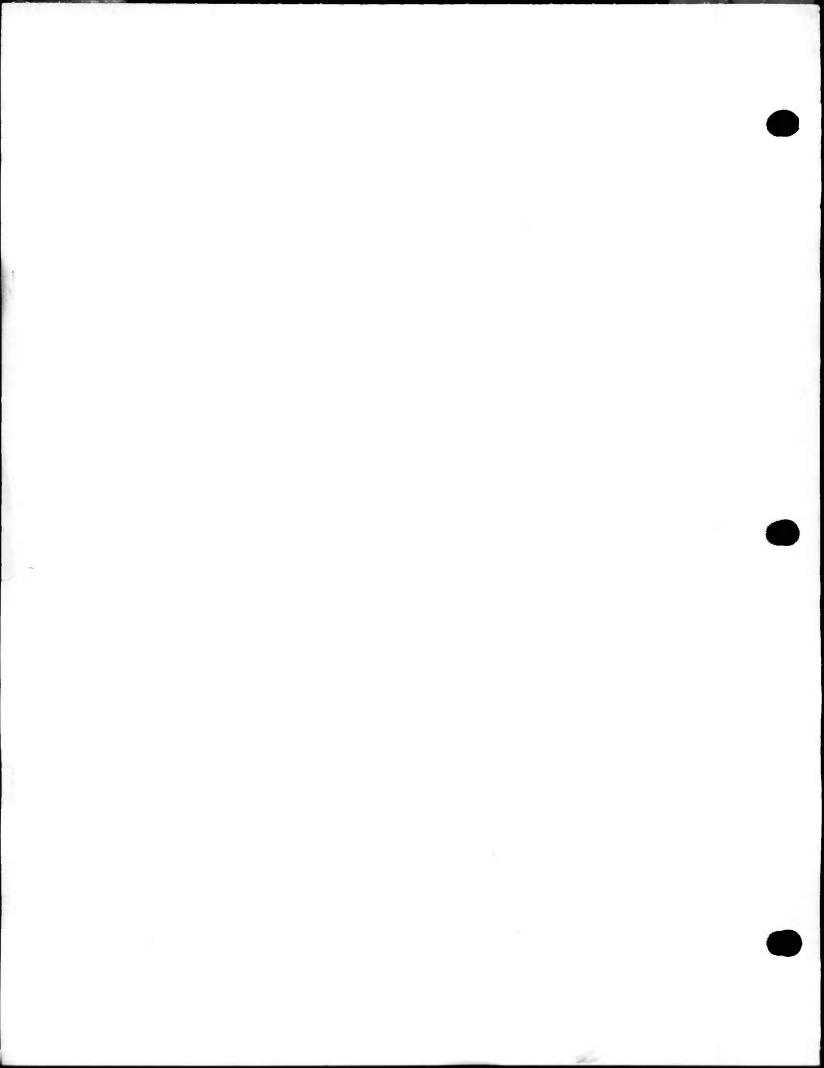
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 rigay be ref | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 standards and the funeral director, page 5 standards and the funeral director and the funeral dire | by the worth 2 tous and dead will be out to the control of the control of the made as and the made of the made of the control of the made of the control of |
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31. DATE FILED (Month, Day, Year)
DEC 1 2 1990

32. REGISTRAR'S SIGNATURE

... ... Wardson - yondell

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | | MENT OF HEALTH | | L HYGIENE REG. NO. | 90 34113 |
|------------------|--|--|---|---|---------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | alvin | Lau | Vrence | 2. DATE MONTO | | YEAR 3. TIME OF DEATH 90 350 AM |
| | 4. SOCIAL SECURITY NUMBER 220-12-2815 | 5. SEX 6. AGI | | F UNDER 1 YEAR IF UNDER 2 ONTHS DAYS HOURS | MIN (Monti | of BIRTH h, Day, Year) -2 -24 | 8, BIRTHPLACE (State or Foreign Country) V. C |
| TOR | 99. FACILITY NAME (If not institution, give at ST HGN-B RESIDENCE OF DECEDENT | Hospital | 1 | Baltu | N OF DEATH | 9c. COUN | NTY OF DEATH |
| DIREC | 100. STATE Md 10b. COUNTY | | 10c. CITY, | TOWH OR LOCATION | | | 16d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL DIRECTOR | 3229 Anelo | s Lane | | 10f. ZIP CODE | 1229 | 10g. CITI | ZEN OF WHAT COUNTRY? |
| B | 11, MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 TYPE IF YES, GIVE WAR OR | S 2 NO | 13. WAS DECENDENT OF If yes, specify Cuban 1 — YES 2 NO | | | 14. RACE — American Indian, Black, White, etc. Specify: Bk. UK |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | 18e. DECEDENT'S U (Give kind of wo life. Do NOT use | rk done during most of working | 166 | KIND OF BUSINESS/IND | unstruction Co. |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Will Robert | Lawrence | e | 16. MOTH | ER'S NAME (First, | Middle, Maiden Sumerne) | |
| 10 | 190. INFORMANT'S NAME (Typo/Print) NET/E Lav | Urence | 3224 | DDRESS (Street and Number | or Rural Route Nurr | Balto, M. | d 2129 |
| | 20e, METHOD OF DISPOSITION 1 M Burlel 2 Cremetion 3 Rem 4 Donation 8 Other (Specify) | oval from State | other place) | TION (Name of comotony, comm | est Ve | + Owin | City or Town, State, 43, Mills, Mil |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | Cagl | | Hanch | +300 U | West Wahash X | tue |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | | each lins. | • | ng, auch ea cer | diec or reapiratory en | Approximats Interval Between Oneat and Death Solwy S |
| CERTIFICATION | Sequentielly liet conditions, if sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | OUE TO (OR A | | Coll las | (Inom | | 2 mos |
| MEDICAL | PART II. Other eignificent condition | na contributing to deati | but not resulting in | the undariying csuea g | jiven in Part I. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 AN NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | EATH (Check only o | | |
| | 1 VES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF INJUR (Month, Day, Yea | Y 28b. TIME | RY WORK? | | er (Specify) SSCRIBE HOW INJURY OC | CCURED |
| BY | I I I I I I I I I I I I I I I I I I I | | | | 201.10 | CATION (Street and Numbe | |
| TED | Accident investigation Accident investigation | 28e. PLACE OF INJU building, etc. (S | JRY — At home, farm, st specify) | reet, factory, office | Ch | y or Town, State) | r or Hural Houte Number, |
| OMPLETED | 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only 1 CERTIFYINO PHYS | building, stc. (S | owledge, death occurre | of at the time, date end place. | , end due to the co | y or Town, State) | 1 |
| TO BE COMPLETED | 2 Accident 3 Sulcide 4 Homicide 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMINI 29b. SIGNATURE AND FITLE OF GERTIFIE | iCIAN: To the best of my kr | owledge, death occurre | d at the time, date end place, in my opinion, death occur | , end due to the co | y or Town, State) suse(e) end manner ee state and place, end due to t | ited. |



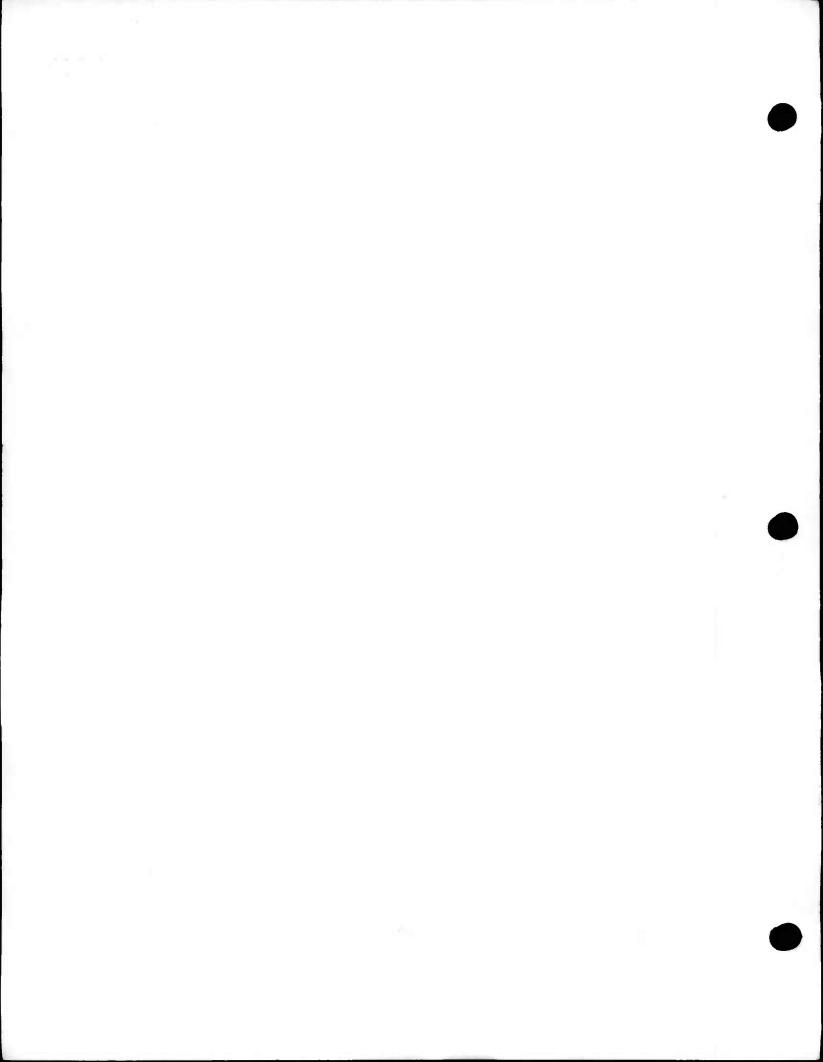
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SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mours after death. Page 6 may be retained by the hospital or attending physician.

NETAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should him 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

NIT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - STATE REGISTRAR | ST | ATE OF MAR | | DEPARTM | | EALTH AND N | | YGIENE | | | 0 1 1 1 | • | |
|--|---------------------------------------|-----------------------------|-------------------|--|---------------------|--|---------------------|-------------------|-------------------------------|----------|---------------------------------------|-------|--|
| 1. DECEDENT'S NAME (First, Mile | | | | | | | 2. DATE OF MONTH | DEATH DAY | | /EAR | 3. TIME OF DEATH | | |
| John J. | IVI O. I | | 05.4- 1 | | .541 | | Decen | | | | 12:25 | | |
| | 1 | | NGE (In yrs. last | YRS. MONT | HS DAYS | IF UNDER 24 HRS, HOURA MIN. | (Month, De | ay, Year) | 8. | Country) | | ign | |
| 225-24-692 90. FACILITY NAME (If not institu | | ★2 ☐ F | 70 | | CITY, TOWN O | R LOCATION OF DE | | 1-20 | 9c. COUNT | Y OF DE | VA. | | |
| | Genera: | | ital | 0.00 | | more Ci | | | | | | | |
| 100. STATE 10 | | | | | | | | | 10d. INSIDE CITY | | | | |
| MD | | | | | | | | | LIMITS? | 10 | | | |
| 100, STREET AND NUMBER | | | | DALL | | . ZIP CODE | | | 109, CITIZEN OF WHAT COUNTRY? | | | | |
| 1338 NORTH | 1 11750 | NE AVE | MILE | | | 1213 | | | USA | | | | |
| TI MARITAL STATUS 12 WAS DECEMENT EVED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 12 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 13 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 14 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBENT OF DISCRETE VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED 15 WAS DECEMBED VED IN U.S. ADMED VED IN U | | | | | | | | - American Indian | | | | | |
| 1 Never Merried 2 Me | rried | ORCES? 1 1 | YES 2- N | 10 | It yee, sp | e, specify Cuben, Mexicen, Puerto Ricen, etc.) Bleck, Wh | | | | | White, etc. | , | |
| 3 Widowed 4 Divorce | d " | TEO, GIVE WAY | JII DAILS | | 1 🗆 120 | A Special | ,. | | | Specify | BLAC | K | |
| 15. DECEDI (Specify only his Elementery/Secondery (0-12 6th Grade) 17. FATHER'S NAME (First, Middle) | ENT'S EDUCATION ghest grade comple | l etect) | 16a. DE | CEDENT'S USU | L OCCUPATION | ON st of working | 16b, KII | ND OF BUS | INESS/INDUS | STRY | | | |
| Elementery/Secondery (0-12) | 1 | ege (1-4 or 5 +) | life. | ive kind of work of Do NOT use reti | ed.) | of the Horning | | | | | | | |
| 6th Grade | | | | Balti | more | Brick | | | | | | | |
| 17. FATHER'S NAME (First, Middl | le, Last) | | | | | 18. MOTHER'S NA | ME Fret Midd | de, Maiden S | Surname) | | | | |
| Leslie | Мо | rton | | | | Bett | У | | C | hea | tman | | |
| | /Print) | | 191 | b. MAILING ADD | RESS (Street a | nd Number or Rural I | Route Number, | City or Town | , State, Zip C | ode) | | | |
| Gwendolyn | Th | omas | 1 | 1902 E | AST I | BELEVED | ERE A | VE./ | Balt | ο., | Md. 21 | 239 | |
| 20e METHOD OF DISPOSITION ↑ Burlet 2/□ Cremetion | | | 20b. PLACE | OF DISPOSITIO | | netery, cremetory or | | | ATION - CI | | | | |
| 4 Donetion 5 Other (Sp | | om State | V T N C | | RTAT. | PK. CEI | М | RA | NDAT. | LST | OWN, M | D | |
| 21. SIGNATURE OF FUNERAL S | ERVICE LICENSE | Ε Λ | 102.11 | , ,,,,,,,, | | D ADDRESS OF FA | | 1 | | 20 1 | 011219 22 | | |
| - Janes | m (| oad | / | | WM. | C. MARCI | н ғ.н | . 11 | 01 E | . N | ORTH A | VE. | |
| 23. PART i. Enter the dise | | | | | | | | | | | Approxima | te | |
| immediate cause (Finsi | rt Isliure. List o | nly one cause | on each line | . | | | | | | | interval Be Onset and | | |
| disease or condition | | linical | cereb | rovasc | ular | Accident | | | | | 0.00 | | |
| resulting in death) | a | DUE TO (OR | AS A CONSE | OUENCE OF): | | | | | | | + | | |
| , | | Arterio | sclero | tic Ca | rdiova | scular D | isease | 2 | | | | | |
| Sequentially list condition | | DUE TO (OR | AS A CONSEC | OUENCE OF): | | | | | | | | | |
| cause. Enter UNDERLYING | 3 | | | | | | | | | | | | |
| CAUSE (Disease or injury that initiated events | | DUE TO (OR | AS A CUNSE | OUENCE OF): | | | | | | | | | |
| Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | d. | | | | | | | | | | | | |
| 5 | | | | | | | | | | _ | | | |
| Acute Track | conditiona con | ntributing to dea nitis | ith but not i | reaulting in th | e underiyin | g csuse given in | Part i. 24 | PERFOR | | | WERE AUTOPSY FIN AVAILABLE PRIOR 1 | m | |
| | | | | | | | 1 | ☐ YES 2 | □ NO | | COMPLETION OF CA OF DEATH? | USE | |
| Chronic Obs | structiv | e Pulmo | nary B | isease | | | | | | | 1 YES 2 N | 0 | |
| | | | | | | | | | | | | | |
| Chronic Obs 25. WAS CASE REFERRED TO BEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 157 Netural 5 Page 158 159 | | | | | | ACE OF DEATH (Ch | eck only one) | | | | | | |
| 1 YES 2 NO | | SPITAL: Inpetient 2 - ER | /Outpatient 3 | | HER: Nursing Hor | ne 5 🗆 Residence | 8 Other (S | Specify) | | | | | |
| 27. MANNER OF DEATH | 1 | 28s. DATE OF INJ | | 28b. TIME OF | 28c, IN | JURY AT | 28d. DESCR | BE HOW I | JURY OCCU | RED | | | |
| | | (Month, Day, Y | ear) | INJURY | | ORK? YES 2 NO | | | | | | | |
| 2 Accident investigation | | | | | | | oute Number, | | | | | | |
| | termined | building, atc. | (Specify) | | | | City or | Town, State) | | | | | |
| 29e. CERTIFIER | VINC BUVEICIAN. | To the heat of my | lenevel edo e de | | ab a de constant | | | | | | | | |
| (Check only one) 2 MEDICA | | | | | | and piece, end due death occured at the | | | | | and manner as at | nted | |
| 3 | | | matron engo | investigation, in | my opinion, | Jeann Occured at the | time, date en | id place, eli | a ade to the | ceuse(e) | elid Melillet ee st | nteo. | |
| 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) 12-08-90 | | | | | | | | | | | | | |
| | | | | | | | | | P 12 | 2 - 08 | 3-90 | | |
| 30. NAME AND ADDRESS OF P | ERSON WHO COM | MPLETED CAUSE O | OF DEATH (ITE | M 27) (Type, Prin | () | | | J. | | | | | |
| | | | | | 14 | | | | | | | | |
| 31. DATE FILED (Month, Day, Yes | 1000 | 32. DEGISTRAR'S | SIGNATURE | and Me | | | | | | | | | |
| ■ DEC 1.2 | 1990 | yuna un | 10000 | | | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

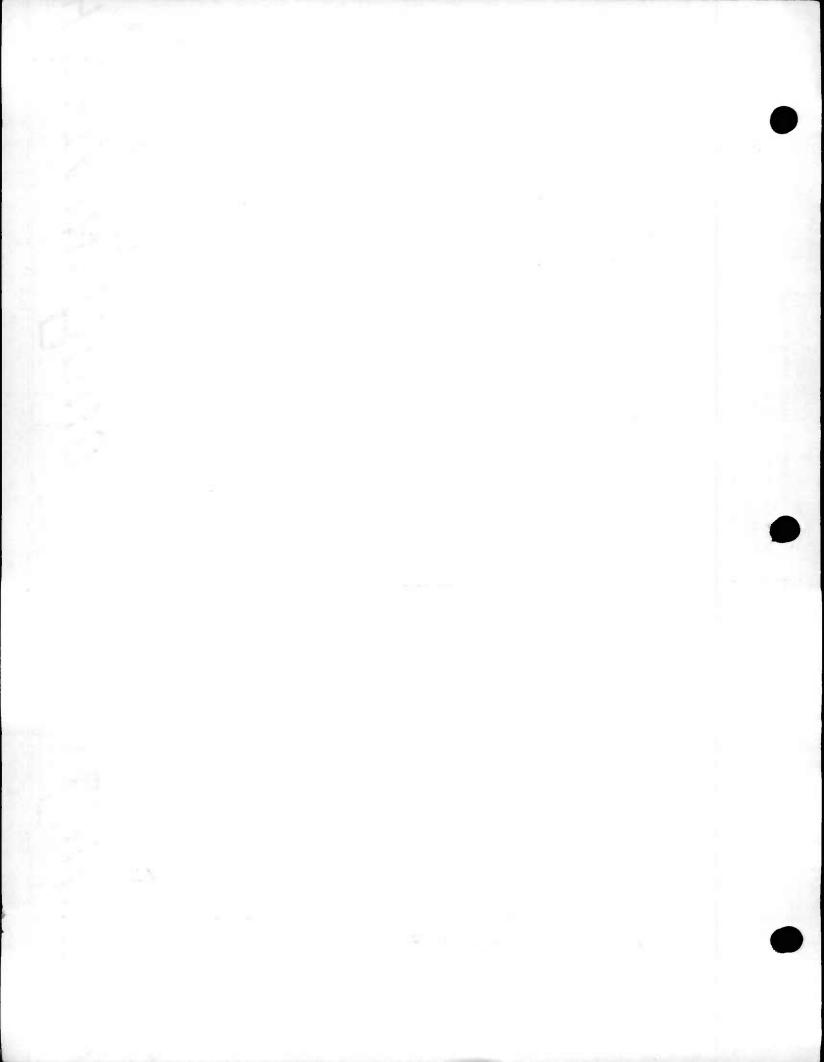
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| THE HOSPITAL OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the control of removal | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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30. NAME AND ADDRESS OF PER
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31. DATE FILED (Morith, Day, Year)

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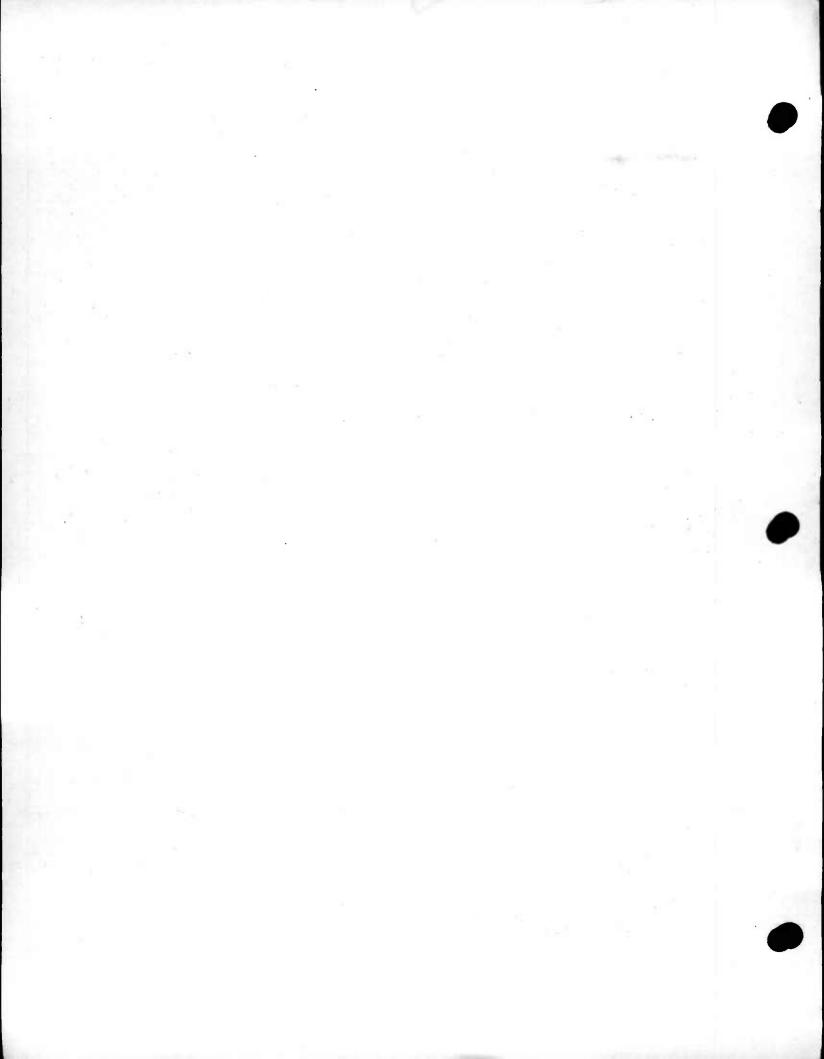
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| 1. DECEDENT'S NAME (Fir | at Alleletta tanti | | | | ICATE | | | REG. NO | 0. | Τ | THE OF BEATH |
|--|---|--|---|--|---------------------------|---|---------------------------|--|-------------------|-------------------------|--|
| | si, Miodie, Liisi) | | EST | ELLE | PA | MARC | USE | MONTH | DAY OF A | | TIME OF DEATH H: 45 AM |
| 072 14 59 | ABER 16 | 5. SEX 1 □ M 🛣 👾 F | | yrs. lest birthday) 77 YRS. | IF UNDER 1 | YEAR IF I | JNDER 24 HRS. JRS MIN. | 7. DATE OF BIRTH Jan . 1, | | Country | CE (State or Foreign |
| Suburban Residence of De | Hospit | | | | | these | CATION OF E | DEATH | 9c. COUNT Mont | | |
| 10e. STATE Maryland | 10b. COUNTY | tgomery | | | r, town of | | | . | • | 1 | d. INSIDE CITY LIMITS? YES 2 NO, |
| 100. STREET AND NUMBE 6611 Mont | | Rd., | | | | 101. ZIP | 20852 | 2 | | N OF WHAT | States |
| 11. MARITAL STATUS 1 Never Married 2 S Widowed XX Di | | 12. WAS DECEDED FORCES? 1 IF YES, GIVE V | T EVER IN U YES | I.S. ARMED | H | yes, specify | Cuban, Mexic NO Spec | NNIC ORIGIN? (Specify Y lair; Puerto Ricen, etc.) lly: | ea or No- 14 | Black, Wi Specify: h | American Indian, hite, etc. |
| (Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4 or 5+) | | | 6a. DECEDENT'S (Give kind of life. Do NOT L | work done du se retired.) | CUPATION pring most of | working | 166. KIND OF B | | STRY | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 17. FATHER'S NAME (First, Middle, Last) Lewis Pearl | | | | 16. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Hartman | | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Michael Marcuse 19a. MAILING ADDRESS (Street and Number or Pural Route Number, City or Town, State, Zip Code) 1220 East West Hwy., Silver Spring, 20a. METHOD OF DISPOSITION XIX Burtlei 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Mt. Lebanon Cemetery. Adelphi, M. | | | | | | Md. | | | | | |
| | | | | | | | | | | | |
| ≥1. SIGNATURE OF FUNEY | AL SERVICE LIC | ENSEE | | | I | ves- | | son Funer ch, Va. | | | |
| 23. PART I. Enter the shock, or iMMEDIATE CAUSE (I disease or condition resulting in death) | heert fellure. | List only one car | se on eec | he death. Do h line. V &J Cu | 11 | | | | piratory erres | it, | Approximate Interval Between Onset and Deeti |
| Sequentially list condificant, leading to immoduse. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death) LA | nediate YING Jury | b. DUE TO | OR AS A C | ONSEQUENCE (| ill op: | r hoc | | • | | | |
| Fever of which thology 1 yes 242NO OF DEA | | | | | | RE AUTOPSY FINDINGS AMABLE PRIOR TO MPLETION OF CAUSE DEATH? | | | | | |
| EXAMINER? 1 YES 2 TOO 27. MANNER OF DEATH | 1 VES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 1 VES 2 DOD 28c. INJURY AT WORK? 1 VES 2 DOD 28c. INJURY AT WORK? | | | | | | | | | | |
| 3 Sulcide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | e Number, | | | | |
| And CONTINUED | RTIEVING PHYS | ICIAN: To the heat o | f my knowler | don donth occur | and at the the | no data and | nlann and de | us to the cause(s) and m | | G. | |



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| SOTAL OR WITENDING PHYSICIAN: The law requires that the death certificate be executed within a | pletely | геша | NYT if item 28 is marked or item 23 shows any injury, or other traumatic event, the |
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| | 1 - STATE REGISTRAR | STATE OF MARY | CERT | TIFICA | TE OF | | | REG. | NO. | | |
|-----------------|--|--|---|--|-----------------------------|---------------------|------------|---|------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | THOMAS C. | | 194 | Wit | 7:1 | | 2. DATE OF DEAT | ser 9 | 1990 | TIME OF DEATN |
| | 159-12-6735 | 1 | E (In yrs. last birtho 73 YF | ARCACCA | HS DAYS | HOURS | MIN. | April Day 13 | ,1917 | Country) | Sylvania |
| | 9e. FACILITY NAME (if not institution, give : | | | 9b. C | CITY, TOWN | OR LOCATE | ON OF O | EATH | 9c. COL | UNTY OF DEA | ТН |
| DIRECTOR | PENINSULA GENE | RAL HOSPITA | L | | SALIS | BURY | , MD | | WI | COMICC |) <u></u> |
| EC | RESIDENCE OF DECEDENT | | | | | | | | | 10 | Id. INSIDE CITY |
| BIO | Maryland Worce | ester | | 0cean | City | y | | | | 1 | LIMITS? |
| AL | 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WI | | | | | | | | | TIZEN OF WHA | AT COUNTRY? |
| 65 1 | | d and Thirty | -Third | | | 2184 | | | | S.A. | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | | If yes, sp | | en, Mexico | NIC ORIGIN? (Specifien, Puerlo Rican, atc | | 14. RACE — Black, V Specify: White | American Indian, thite, etc. |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDEI (Give kin- life. Do Ni | NT'S USUAL d of work do !OT use retire | L OCCUPATE one during mo | ION oat of worki | ing | 16b. KIND OF | F BUSINESS/IN | | |
| APL | 12 | 2 | Prod | uctio | on M | ANAC | IER | Indep | endent | Can (| Co. |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOT | HER'S N/ | ME (First, Middle, Ma | | | |
| BE (| Frank Mulvihill | | | | | | | rroll | | | |
| TO E | 190. INFORMANT'S NAME (Type/Print) Margaret R. Mulv | /ihill | | iling addr me as | | and Numbe | r or Rural | Route Number, City o | r Town, State, Z | ip Code) | |
| | 20a. METNOD OF DISPOSITION 1 □ Burlel 2 □ Cremetlon 3 □ Ren | novel from State | 20b. PLACE OF DI | | | | | | c. LOCATION - | - City or Town | , State |
| | 4 🗋 Oonetion 5 🗆 Other (Specify) | | Parkwoo | | | | | | Parkvi | 11e, 1 | Md. |
| 20. Parkwood 1 | | | | | | k Tow | son | Funeral I., Towso | - | | , |
| | The second secon | complications that caus List only one cause on | ed the death. | Do not an | | | | | | | Approximata Interval Betwee Onset and Deat |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | S. INTICA | CEREN- | CE OF): | 1481 | 4470 | MA | | | | 16 hou |
| CATION | Sequentially list conditions, If any, leading to immediate OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ERTIFICA | cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | C. DUE TO (OR AS | S A CONSEQUENC | CE OF): | | | | | | | |
| 8 | | d | | | | | | | | | <u> </u> |
| MEDICAL | 1 YES 2 NO OF DEATH? | | | | | | | | | VAILABLE PRIOR TO OMPLETION OF CAUSE | |
| AN: | | | | | | | | | | | |
| Ö | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTI | 26. P | LACE OF E | DEATN (C) | heck only one) | | | |
| PHYSICI | 1 TYES 2 NO | 1 Inpatient 2 ER/O | | OA 4 🗆 | Nursing Hor | | esidence | 6 Other (Specify | | | |
| ву Рн | 1 Natural 5 Pending 2 Accident investigation | 28e. DATE OF INJUR (Month, Day, Year | 1) | D. TIME OF INJURY | M 1 🗆 | | □ NO | 28d. DEŞCRIBE H | OW INJURY OF | CCURED | |
| TED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, stc. (S | RY — At home, fa pecify) | erm, street, | factory, offic | ca | | 261. LOCATION (S City or Town, | | er or Rural Rou | te Number, |
| COMPLE | ana) | SICIAN: To the best of my kn IER: On the bests of examina | | | | | | | | | nd manner as stated. |
| ш | 29b. SIGNATURE/AND TITLE OF/CERTIFIE | ER | | | | 29c. LIC | ENSE NU | MBER | 29d. DA | TE SIGNED (M | lonth, Day, Year) |
| TO B | 15-118cc | ٢., | | | | DE | 38: | 587 | • | 12/9 | 190 |
| - | 30. NAME AND ADDRESS OF PERSON WI EDWIN H. BELLIS | HO COMPLETED CAUSE OF | S. DIVI | (Type, Print) | T. SA | LISB | m | MI) 2 | 1801 | | |
| | EDWIN H. BELLIS 31. DATE FILED (MONTH, Day, Joan) 19 | 90 32. PER STATE OF | PHILIDANS PROPERTY | Printer Street | | | | | | | |



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| OF VITAL RECORDS, P.O. BOX 1314 | PHYSICIAN |
| DIVISION | PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed |
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| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTI | | | MENTAL HYGIEN | | | |
|---------------|---|---|---|---------------------------|--------------------------------|--|-----------------------|--|--|
| Ì | 1. DECEDENT'S NAME (First, Middle, Last) | Doris E | | MINNER | - | 2. DATE OF OEATH December | | - 11 | |
| | 4. SOCIAL SECURITY NUMBER 219-30-3709 | 1 □ M 2 💢 F 58 | YRS. | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. OATE OF BIRTN (Month, Day, Year) SEPT . 27, 1 | .932 | BIRTNPLACE (State or Foreign Country) MARYLAND | |
| TOR | 9a. FACILITY NAME (If not institution, give st FRANKLIN SQUARE | | 9 | | TMORE | EATH | Baltimore County | | |
| DIRECTOR | 10a. STATE 10b. COUNTY MARYLAND | | | TOWN OR LOCATE | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 527 N. CLINTON | ST. | | 10f. | ZIP CODE 21205 | | | N OF WHAT COUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3XXWidowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 XNO | It yes, spe | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yen, Puerlo Ricen, etc.) | | . RACE — American Indian, Black, White, atc. Specify: WHITE | |
| ETED | 15. DECEDENT'S EDU- (Specify only highest grade Elamentary/Secondery (0-12) | | 18a. DECEOENT'S US (Give kind of wor life. Do NOT use i | k done during mas | N t of working | 16b. KIND OF BU | JSINESS/INDUS | TRY | |
| COMPLETED | NA 17. FATNER'S NAME (First, Middle, Last) | NA | CLERK | 1 | 18. MOTHER'S NA | BAN ME (First, Middle, Maidel | | NDUSTRY | |
| H | SAMUEL A. JOHNSO |)N | 19b. MAILING A | DDRESS (Street ar | | B. HOFFMA | | ode) | |
| 2 | KAREN COLLIFLOWER | | | ILLBURN | AVE, BA | ALTIMORE, | MD. 21 | , | |
| | 1XXBurial 2 Cremation 3 Ram 4 Donation 5 Other (Supple) | oval from Statio | PARKWOOD | CEMETER | RY | BA | LTIMOR | E, MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | ENSEE JULY | | 3331 E | NEK FUNI BREHMS LA | ERAL HOMES ANE, BALTI | , INC. | MD. 21213 | |
| | IMMEDIATE CAUSE (Final | e. Metastatio | sch line. | nt Mela | - 0.000 070.070.000 | h aa cerdiac or rea | biretory arreat | t, Approximate interval Between Onset end Death | |
| CERTIFICATION | Sequentially liet conditions, If sny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERT | resulting in death) LAST | d | | | | | | | |
| MEDICAL | PART II. Other eignificent condition | is contributing to death be | ut not resulting in | the underlying | ; cause given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF OEATN (CH | neck only one) | | 1 | |
| YSIC | EXAMINER? V 1 U YES 2 NO | HGSPITAL: 1 Nonpatient 2 ER/Outp | atlant 3 DOA 4 | | | 6 Other (Specify) | | | |
| ву РН | 27. MANNER OF DEATH 1 💢 Natural 5 🗀 Pending 2 🗀 Accident Investigation | (Month, Day, Year) | 28b. TIME INJUI | RY WO | URY AT RK? (ES 2 NO | 28d. DEŞCRIBE HOW | INJURY OCCUP | RED | |
| | 3 Suicide 8 Could not be 4 Homicide datermined | 26s. PLACE OF INJURY building, stc. (Spec | — At home, farm, str | reet, factory, office | | 28t. LOCATION (Stree City or Town, Stat | t and Number or a) | Rural Route Number, | |
| COMPLETED | (Orlock Orly) | ICIAN: To the best of my knowl ER: On the basis of examination | | | | | | l. cause(a) and manner as stated. | |
| BE | 29b. SIGNATURE AND VITLE OF CERTIFIE | and | | | 29c. LICENSE NU | MBER N/A | 29d. DATE S | BIGNED (Month, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | V | ATN (ITEM 27) (Type, F | | n Sauare | - | 21 | 237 | |
| | 31. DATE FILEN @ A MADE (NOW) | 32. REGISTRAR'S SIGN | ATURE and | TUINTI | ii oquui (| C DI IVC | | | |

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mil. Pages 1, 2, 3 should

| | FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR ERTIF | | | | | MENTAL | HYGIEN REG. NO. | E | 90 | 34118 |
|-------------------|--|--|--------------------------|----------------|------------|--|-------------|-------------------|--|--|-------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | OF DEATH | | | 3. TIME OF DEATH |
| | CORNELIA | | | M | OODY | | | | MDNT- | 30 | | YEAR | 4:40 P M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. les | t birthday) | IF UNDER | 1 YEAR DAYS | IF UNDE | R 24 HRS. MIN. | (Month, Day, Year) Country) | | | PLACE (State or Foreign | |
| | 9e. FACILITY NAME (If not institution, give a | | 9.1 | Tho. | 9b. CITY | r, TOWN C | R LOCAT | ION OF DE | 9 - 2 2 - 0 9 DEATH 9c. COUNTY OF DEATH | | | | EATH |
| E O | 5519 Minnoka | | | | | Ba1 | timo | re | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | Y | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. INSIDE CITY LIMITS? |
| | MD | | | | Bal | tim | | | 1 TYES 2 | | | | 1 TES 2 NO |
| ERAL | 100. STREET AND NUMBER 5519 Minnoka | | | | | 101 | . ZIP COD | E | | | 10g, CITIZ | EN OF | WHAT COUNTRY? |
| BY FUNER | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexica 1 YES 2 NO Specifi | | | | oxican, Puerto Rican, etc.) Black, White Specify: | | | | E - American Indian, k, White, etc. hy: White | | | |
| ETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | completed) | | | | | | 16b | KIND OF BU | SINESS/INDU | JSTRY | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOT | HER'S NA | ME (First.) | Viddle, Maiden | Surname) | | |
| w I | | y a wontard in | | | | | | | | 1,1,1,1,1,1 | | | |
| 10 18 | 19e. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 | n state | 20b. PLACE other pl | OF DISPO | ISITION (N | ame of ce | netery, cre | matory or | | 20c. LO | CATION — C | City or To | own, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE Rona | Wade | e,Di | | | | | | TATE ,Bal | | | Y BOARD 21201 |
| | 23. PANT I. Enter the diseases, or shock, pr heart failure. IMMEDIATE CAUSE (Final disease pr condition resulting in dasth) | | use on aach ling | . | | | | | | | iratory arm | est, | Approximata Interval Batwaan Onset and Death |
| z | | DUE TO | (OR AS A CONSE | OVENCE | OF): | | | | | | | | |
| CATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO | (OR AS A CONSE | QUENCE (| OF): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO | (OR AS A CONSE | OUENCE (| OF): | | | | | | | | |
| ا بر | PART II. Other significant condition | ns contributing to | death but not | resulting | In the u | ındariyin | g cause | given in | Part I. | I. 24s. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO | | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| ME | | | | | | | | | | | | | 1 TYES 2 X NO |
| A | 25. WAS CASE REFERRED TO MEDICAL | T | | | | 26 B | LACE OF | DEATH (Ch | ack only o | inspe | ction | | |
| SICI | EXAMINER? | HOSPITAL: | ☐ ER/Outpatient : | 3 🗆 DOA | OTHE | R: | - 1000 | Residence | | | | | |
| PHYSICIAN: MEDICA | 27. MANNER OF DEATH | 28e, DATE O | | 28b. TI | | 28c. IN W | JURY AT | | | SCRIBE HOW | INJURY OCC | URED | |
| B | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be | Ing digetion M 1 VES 2 NO 28s. PLACE OF INJURY — At home, farm, street, factory, office 28s. PLACE OF INJURY — At home, street, factory, office 28s. PLACE OF INJURY — At home, street, fa | | | | | | Floute Number, | | | | | |
| | 4 Homicide 6 Could not be | building | , etc. (Specify) | , | ,, | , | | | City | or Town, State |) | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS | | | | | | | | | , , | | | (e) end menner as stated. |
| BEC | 296 SIGNATURE AND TITLE OF CERTIFIE | 0,10 | | | | | | CENSE NU | MBER | | | | D (Month, Day, Year) |
| ٥ | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAL | JSE OF DEATH (ITI | | | | | OCME | | | | 12-1 | |
| | Margarita A. Kor | ell. M.D | AR'S SIGNOUNI | 111 | Pel | n St | reet | | Ва | 1timo | re, MI | 21 | 201 |
| | DECLOSION | 3z. HEGIBIH | ent o di cing aut | | | • | | | | | | | |

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| BALTIMORE, MARYLAND 21203-3146 | s after death. Page 6 may be retained by the hospital or attending pl | Setsched |
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| SALTIMORE, MARYLAND | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Trous after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be fised within 72 hours after death with the State Dept. of Health and Mental Hyptene prior to bustal, cremation, or removal. | 99 |
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| 1. DECEDENT'S NAME (First, Mic | | | FRA | CERTIF NK CHA | | | | 2. DATE O MONTH | REG. NO. | | YEAR | 3, TIME OF DEATH |
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| A SOCIAL SECURITY NUMBER | | Michae | PERSONAL PROPERTY. | rs. Aust birthologi | F UNDER 1 Y | | UNDER 24 HRS. | Z. DATE O | - 11- | 90 | Marine and A | 5:45 A PLACE (State or Foreign |
| 216-01-554 | | 1×42DF | 10-41-41-411-55 | 36 YAS. | | | DURS MIN. | (Manth. | Day: Year) | . | Country | , , |
| Se. FACILITY NAME (If not institu | | | | 30 | 96. CITY, TO | OWN OR L | OCATION OF DE | - | 08-0 | | ITY OF DE | aryland EATH |
| Baltimore Co | General | General Hospital | | | Ran | undallstown | | | | Baltimore | | |
| | b. COUNT | | | 1000 | Y, TOWN OR | | | | | | | 10st. IMSIDE CITY LIMITS? |
| MD | E | Baltimo | re | R | andal | 2000 | 04032707 | | | | | T YES 2 NO |
| 920 Rarde | we11 | Road | | | | 101. 29 | 21228 | 3 | | | ZEN OF W | HAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Me 3 9 9 Ndowed 4 Divorce | STATUS 12. WAS DECEDENT EYER IN U.S. ANMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— FORCES? 1 YES 22 NO 17. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 17. YES 2 NO Specify | | | | | 14. RACE Black Specif | - American Indian, , White, etc. | | | | | |
| 15. DECEDE | ENT'S EDU | CATION | 1 1 | te. DECEDENT'S | | | | 16b. | KIND OF BUS | HNESS/INS | USTRY | |
| (Specify only his Elementary/Secondary (0-12) | Contract of the last of the la | College (1-4 or 5 | +) | (Ghe kind of a the Do NOT a | work done dur se mitred.) | ring most at | f working | | | | | |
| 8 | | 200 | | Retir | e d | | | | Sale | smai | 1 | |
| 17. FATHER'S NAME (First, Middle | | | | | | 38 | I. MOTHER'S NA | ME (First, M | kddla, Maktan | Surname) | | |
| John Mic | 311,140,41,50 | | | T | ******** | | Mary Number or Purer | Muri | | - Marie Marie | C-41 | |
| Dennis | | nael - | Son | 1217-1-2 | | | 1 Rd,1 | | 27.00 | 0.000 | TOTAL C. | |
| 20s. METHOD OF DISPOSITION 1 Burtal 2 Cremation | | | 20b, P | LACE OF DISPO | SITTON (Name | m of comotiv | ev commutary or | | 20c. LO | - MOITAC | City or Tor | wn. State |
| 21. SIGNATURE OF FUNERAL S | 3 Rem pecify) | | - 0 | de, Di | r 22. NA | AME AND A | S | | PATE | ANA | POME | BY BOARD 21201 |
| 21. SIGNATURE OF FUNERAL S | 3 Rem poly) privice Li pases, or rt fallure. | complications the | ld Wa | de , Di ,/4/1//// he death. Do n | r 22. NA 6: | AME AND A | ADDRESS OF FA | to S | FATE t,Bal | ANA! | rome md 2 | BY BOARD 2 1 2 0 1 |
| 21. SIGNATURE OF FUNERAL S 23. PART I Enter the disease or condition | 3 Pennocky) ubryice Li sases, or ri failure. | complications the List only one ca | at caused if use on each | de Di Le Di Le death. Do n | not enter th | AME AND A | ADDRESS OF FA | to S | FATE t,Bal | ANA! | rome md 2 | BY BOARD 2 1 2 0 1 Approximate Interval Between |
| 23. PART L/Enter the dise shock, or hear immeDiate CAUSE (Final disease or condition resulting in death) Sequentially list condition if any, leading to immedia cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | 3 Permonal State of the Control of t | a. Meta Due To c. Due To d. | at caused if use on each | the place) The death. Do in line. The death of the consequence of th | not enter the | AME AND A | ADDRESS OF FA | to S | FATE t,Bal | ANA TANA TANA TANA TANA TANA TANA TANA | FOME | Approximate interval Between Onset and Deat |
| 23. PART L/Enter the dise shock, or hear immediate or condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Sequentially list condition resulting in death) Ascriber UNDERLYING CAUSE (Disease or Injury that inlitated events resulting in death) LAST PART II. Other significant Ascriber VALLETTE STANDARD TO REXAMINERTY 1 YES 2 NO 25. WAS CASE REFERED TO REXAMINERTY 1 YES 2 NO 27. MANNER OBERTH 1 Neture 5 Per Accident 3 Suicide 6 Co | 3 Removally Service Life Servic | DUE TO DUE TO C. DUE TO DU | at caused the second of the se | The death. Do in hine. C Reconsequence of the consequence of the cons | not enter the control of the under t | he mode Cour lerlying co | ADDRESS OF FA | Part I. Part I. Pack only one 6 Other 284. DES | PATE t, Ball lac or respi | AUTOPSY MAD NAUTOPSY POME MD 2 | Approximate Interval Between Onset and Death Death Onset and Death Death Onset and Death Dea |

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2. DATE OF DEATH

7. DATE OF BIRTH

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign

Gradu

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Marthews

6. AGE (In yrs. last birthday)

| aw requires that the death certificate be executed within 2 mounts after death. Page 6 may be retained by the hospital or attending | s been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as i ept. of Health and Mental Hyglene prior to bunial, cremation, or removal. |
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| res that the de | igned by the a |
| aw requir | s been s |

North Carolina 239-12-6443 (Month, Day, Year) 07-04-16 74 YRS. 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Bon Secours Hospital Baltimore, Md DIRECTOR RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10d. INSIDE CITY LIMITS? 10b. COUNTY 1 X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Grove 21216 plar 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-12. WAS DECEDENT EYER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yes, specify Cuben, Mexicen, Puerto Ric 1 TES 2 NO Specify: 1 Never Merried 2 Merried Black BY 3 Widowed 4 Divorced 9 18e. DECEDENT'S USUAL OCCUPATION
(Oive kind of work done during most life. Do NQT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) ruck 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) Hews Labella notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and No 2 ble 0 208 METHOD OF DISPOSITION å 20b. PLACE OF DISPOSITION (Nert examiner must Burial 2 Cremation 3 Re 4 Donetion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 20 00 wabash medicai 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onset and Death **IMMEDIATE CAUSE (Final** the disease or condition resulting in death) 246 event, shows any Injury, or other traumatic MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediata cause. Enter UNDERLYING Emps CAUSE (Disease or injury DUE TO OR AS A CONSEQUENCE OF: that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AWAII ARLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO t | YES 2 NO PHYSICIAN: 23 certificate has 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item ! HOSPITAL: **EXAMINER?** OTHER: 1 YES 2 NO 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 6 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED with t marked, 1 Natural м 1 YES 2 NO DIRECTOR: After the hours after death v ВУ 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is r 3 Suicide 8 Could not be COMPLETED 4 Homicide MPORTANT: If Item 29e. CERTIFIER 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner se stated. FUNERAL (2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end pleca, end due to the ceuse(e) and menner as atteted. 29c. LICENSE NUMBER 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIONED (Month, Day, Year) BE THE BE morande and 223 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WICRANDA ST. PAUL 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

HOSPITAL OR ATTENDING PHYSICIAN:

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| | INFCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit perranged and the state Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | |
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| PHYS | RECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 prous after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | flem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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Pages 1, 2, 3 should

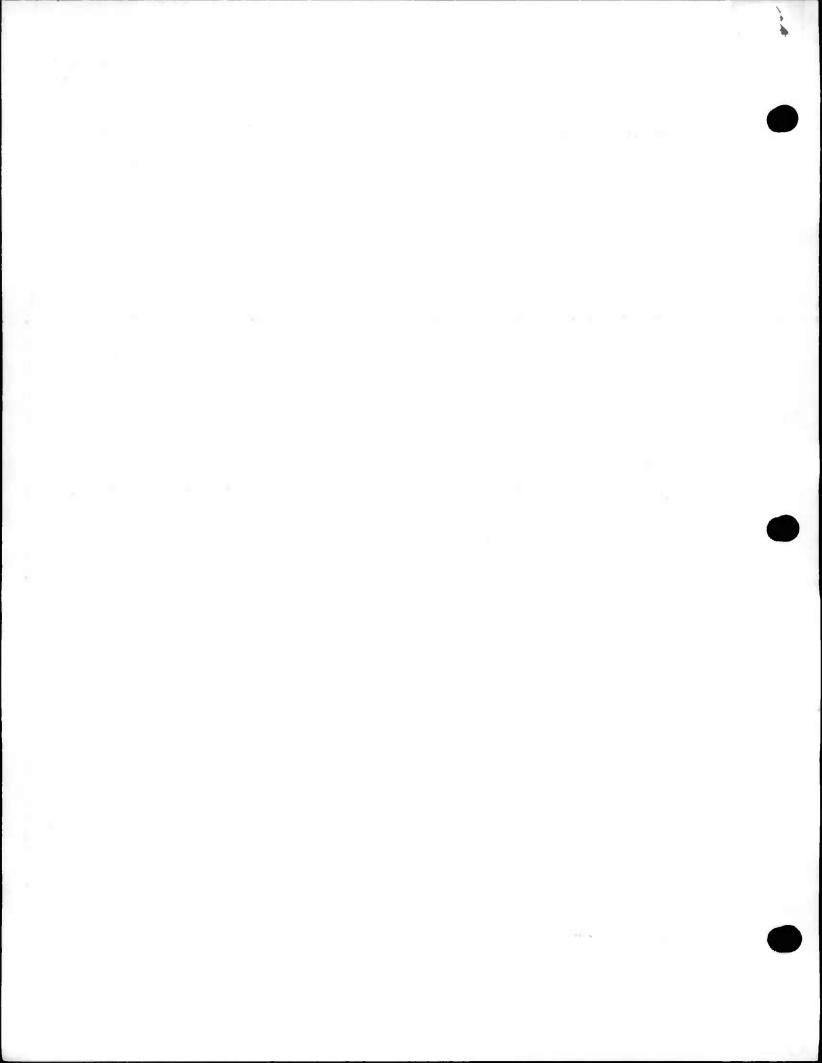
36121 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH indberg NICEI 43 AM am 12 0 8. AGE (In yrs. lest birthday) 4. SOCIAL SECURITY NUMBER 7, DATE OF BIRTH IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign (Month, Day, Year) 6/18/2 1 M 2 - F 229-24-9642 VIRGINIA 9b. CITY, TOWN OR LOCATION OF DEATH 9e. FACILITY NAME (If not institution, 9c. COUNTY OF DEATH alls ton HXXXXXXXX DIRECTOR Leneral FALLSTON HARFORD RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 TES 2 NO MD HARFORD DARLINGTON 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f, ZIP CODE USA 21034 1921 POOLE 12. WAS DECEDENT EVER IN U.S. ARMED 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No. 14. RACE — American Indien, Black, White, atc. ORCES? 1 TYES 2
YES, GIVE WAR OR DATES If yes, epecify Cut ben, Maxicen, Puarto Rican, atc.) FORCES? 1 Never Married 2 Married 1 TES 2X NO Specify Specify ВУ 3 Widowed 4 Divorced WW WHITE ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16h KIND OF BUSINESS/INDUSTRY (Specify only highest grade co. (Give kind of work done life. Do NOT use retired.) Elementary/Secondery (9-12) College (1-4 or 5 +) CIVIL SERVICE COMPL 8 CIVILIAN GUNNER 17 FATHER'S NAME (First Middle Last 18. MOTHER'S NAME (First, Middle, Malden Surname) MATHEW NICELY NANNIE Μ. MOORE 19a. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1712 GRANITE RD., DARLINGTON, MD., 21034 CAROLYN F. WITMER 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or other place) 20e. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 1)∑Surial 2 ☐ Cremetion 3 ☐ Rem AIR BEL MEMORIAL AIR, Donation 5 - Other (Specify) GARDENS 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Khin let HARKINS F.H.INC., DELTA, PA., 17314 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between **Onsat and Death** IMMEDIATE CAUSE (Final disease or condition resulting in daeth) 0 CERTIFICATION Sequentially list conditions, TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERF AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Oulpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 1 Natural M 1 YES 2 NO ВУ Investigation 2 Accident 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide COMPLETED 8 Could not be 4 Homicide 29e, CERTIFIER 1 CERTIFYING PHYSICIAN: To the bast of my knowledge, death occurred at the time, date end place, and due to the cause(e) and menner ee stated. 2 MEDICAL EXAMINER: On the beels atigation, in my opinion, death occured at the lime, data end piece, end due to the cause(a) and manner ee stated.

29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNEO (Month, Day, Year) sen

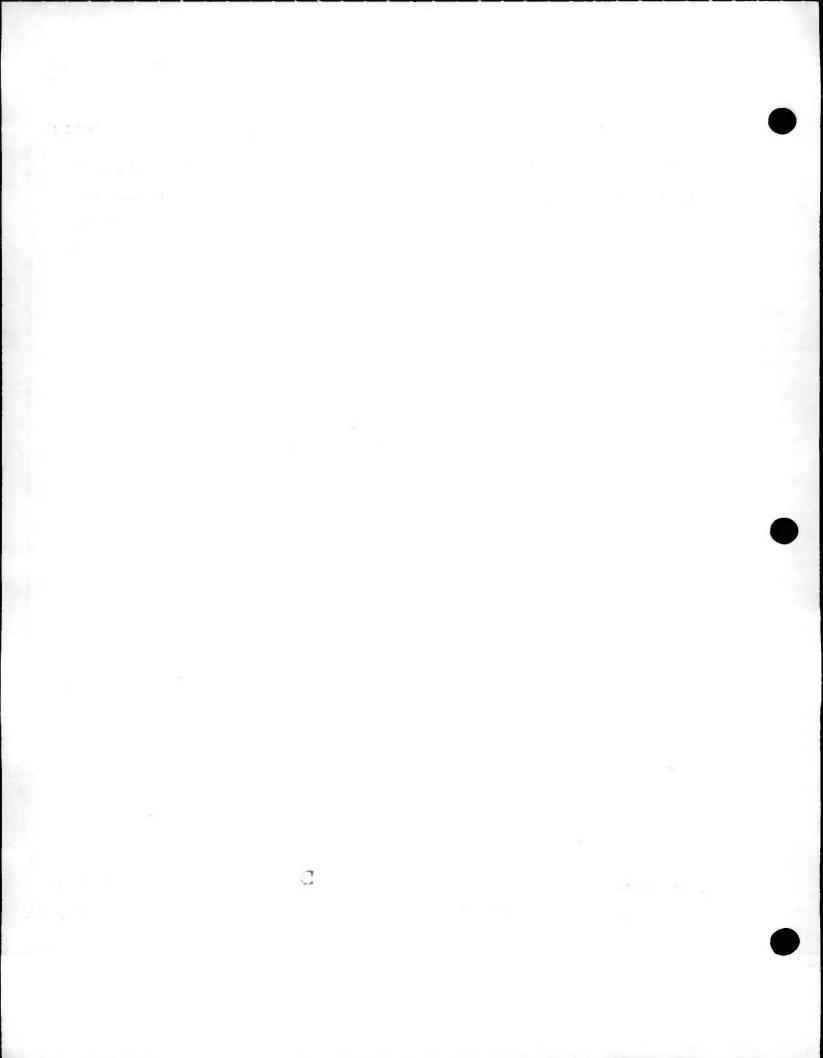
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year) DEC 1 2 1990

32. REGISTRAR'S SIGNATURE relia Daydson-Handell



| | 1 - FOR STATE OF MARYLAND / C | DEPARTME | | | | GIENE G. NO. | 3 0 | 0 1 1 1 1 1 1 |
|---------------|--|--|----------------------------|--|------------------------------|--|---------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Dallas Newton | | | | 2. DATE OF DE MONTH | DAY | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 2.5 - 28 - 0396 See FACILITY NAME (If not institution, give street and number) 5. SEX 6. AGE (In yrs. In- | 1 M 2 G YRS. MONTHS DAYS HOURS MIN. | | | | TTH Ybar) 3-23 9c, C | 8. BIRTHE Country | .C. |
| STOR | Baltimure County Greneral Hospital Randalls | | | | NW | G | teltin | wre |
| DIRECTOR | Md. | TV 10c. CITY, TOWN OR LOCATION Baltimore | | | | | | 10d. INSIDE CITY LIMITS? 1 XXES 2 \(\text{NO} \) |
| FUNERAL | 234 N. Monastery Ave. | | 10f. | ZIP CODE 21 | 229 | | I, S, A. | |
| B | 11, MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12, WAS DECEDENT EVER IN U.S. AI FORCES? 1X YES 2 IF YES, GIVE WAR OR DATES WWIII | | It yes, spe | NDENT OF HISPAN city Cuben, Mexica 2X NO Specify | n, Puerto Rican, | | - 14. RACE Black, Specify | |
| COMPLETED | (Specify only highest grade completed) ((Chilene (1-4 or 5 +) | ECEDENT'S USUA Sive kind of work of D. Do NOT use reth Disabl | lone during mos ed.) | N t of working | 16b. KIND | OF BUSINESS/ | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Lest) James Newton | | | | erine | Harri | s | |
| 2 | Mrs. Edna Newton | 96. MAILING ADD | | N. Mon | | | | 21229 co., Md. |
| | Sem_METHOD OF DISPOSITION 20b. PLACE Other (Specify) 20b. PLACE Other (Specify) Cal | of disposition | Fore | etery, cremetory or | | 20c. LOCATION Owing | | nn, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 4) | Jam 170 | o ADDRESS OF FAMILES A. I | Mortor ens St | . Bal | to., | Md. 21217 |
| | 23. PART I. Enjer the diseases, or complications that caused the dependence of the shock, or heart fallure. List only one cause on each line immediate CAUSE (Final disease or condition resulting in death) DUE TO (ORAS A CONSE | eeth. Do not a a. OUENCE OF): | nter the mod | le of dylng, sucl | h as cardiac o | or reaplratory | arrest, | Approximeta interval Between Onset end Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| MEDICAL | PART II. Other algorificant conditions contributing to death but not Hyperglycemia, Hypercule Accident. | | | - | | WAS AN AUTOP PERFORMED? YES 2 NO | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL. EXAMINER? 1 YES 2 HO | | HER: | ACE OF DEATH (Ch | | ocify) | | |
| BY PHYSICIAN | 27. MANNER OF DEATH 1. Hatural S Pending (Month, Dwy, Hear) 2 Accident Investigation | 26h. TIME OF INJURY | 28c. INJI WO M 1 Y | JRY AT RK? ES 2 NO | 28d. DESCRIB | E HOW INJURY | OCCURED | |
| | 3 Suicide & Could not be determined 26s. PLACE OF INJURY — At h building, etc. (Specify) | ome, farm, street | , factory, office | | 28f. LOCATION City or Tow | (Street and Num vn, State) | nber or Rural R | oute Number, |
| COMPLETED | 25e. CERTIFIER (Chack only comp) CERTIFYING PHYSICIAN: To the best of my knowledge, doth occurred at the time, data end place, and due to the cause(s) and manner as stated. MEDICAL SYMMER: On the best of my knowledge, doth occurred at the time, data and place, and due to the cause(s) and manner as stated. | | | | | | | |
| TO BE | 298. SIGNATURE SADDRESS OF PERSON MAD COMPLETED CAUSE OF DEATH (IT | 0 | | 29c. LICENSE NUI | | 29d. | DATE SIGNED | (Month, Day, Year) |
| | Poultimore County Greneval Ito 31. Date Filed (Morth, Day, Har) DEC 1 2 1990 Julia Davidson-Randal | spitul | <u>5401</u> | OldCo | urt R | d.,Ra | ndall | stown, MD |



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Zerricurs after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached a study within 72 hours after death with the State Best, of Health and Mental Hoolene orior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR STATE REGISTRAR | STATE OF M | ARYLAND / DEPAI CERTIF | | | | MENTAI | HYGIEN REG. NO. | E - | , 0 | 09120 |
|---------------|--|--|---|------------------------------|---------------------------------|----------------------|--------------|--------------------|---------------|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | 2. DATE | OF OEATH | Y | YEAR | 3. TIME OF DEATH |
| | Catharine Ja | | | | | | 12 | | 7 9 | 90 | 9:00 PM |
| | 4. SOCIAL SECURITY NUMBER | The state of the s | 6. AGE (In yrs. lest birthday) | MONTHS DAVE HOURS MIN | | | | 0F BIRTH 2-13- | 1/ | 6. BIRTH Countr | IPLACE (State or Foreign y) |
| | 364-03-8394 9a. FACILITY NAME (If not institution, give | 03-8394 | | | | ATION OF D | | Z-13- | 9c. COUNT | | WYORK |
| Œ | Memorial Hospital | | | | | ALION OF D | EAIR | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | ston | | | | Tal | DOI | |
| DIRECTOR | | | | TY, TOWN OF | | | | | | | 10d. INSIDE CITY LIMITS? |
| - | MD Talbot 10s. STREET AND NUMBER | | | East | 101, ZIP C | OOF | | | 10a CITIZ | EN OF V | 1 TYES 2 NO |
| ERA | PO BOX 744 | | | 21601 | | | | | U | | |
| FUNERAL | 11. MARITAL STATUS | | EVER IN U.S. ARMED | 13. W | AS DECENDEN | IT OF HISPA | NIC ORIGIN | ? (Specify Yea | or No— | 14. RACI | — American Indian, |
| BYF | 1 Never Married 2 Married 3 Widowed 4 Differed | IF YES, GIVE WA | P OR DATES | | yes, specify C | | | Rican, etc.) | | Speci | |
| | 15. DECEDENT'S ED | DUCATION | 16a. DECEDENT | USUAL OC | CHPATION | - | 166 | , KIND OF BUS | INESS/INDI | ISTRY | WIIICC |
| COMPLETED | (Specify only highest gra Elementary/Secondary (0-12) | de completed) College (1-4 or 5+) | (Give kind of | work done du se retired.) | iring most of w | orking | | | | | |
| 릴 | 12 | 4 | Homen | naker | | | | Home | 2 | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | Middle, Malden | | | |
| BE | Cassius Quim | by Cratty | | | | ouis | | | alme1 | | |
| 5 | George D. Ol | ds | PO PO | BOX | Street and Nur. 744 | nber or Rural Eas | ton, | ber, City or Town | 2160 | Dade) | |
| | 20s. METHOD OF DISPOSITION | | 20h. PLACE OF DISPO | SITION (Nem | e of cemetery, | crematory or | | 20c. LO | CATION — C | aty or To | wn, State |
| | 1 Burial 2 Cremation 3 Re Comparison Security Comparison Comp | | other place) | | | | | | | | |
| | 21. SIGNATURE OF FUNDMAL SERVICE | Ronal | d Wade, Di | 22. N | AME AND ADI | PRESS OF F | S I | TATE | ANATO | YMC | BOARD |
| | / Smay/ | unece | | | | | | | | | 21201 |
| | 23. PART I. Enter the diseases, o shock, or heart failure | r complications that a. List only one caus | caused the death. Do se on each line. | not anter t | he mode of | dying, suc | ch as card | flac or respi | ratory arre | st, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | | BOOL | . (| 7-7 | 4 | | | | | Onset and Death |
| | resulting in death) | DUE TO | OR AS A CONSEQUÊNCE O | | ras | | | 1.1 | | | Thus |
| z | | - Lyster | 10 Me | um | w E | 11 CL | ha | litis | | | 129 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (| OR AS A CONSEQUENCE (| OF): |) | C |) | | | | |
| FIG | CAUSE (Disease or Injury that Initiated events | c | OR AS A CONSEQUENCE (| OF): | | | | | | | 1 |
| H | resulting in death) LAST | d | | | | | | | | | |
| | PART II. Other significant conditi | ons contributing to | death but not resulting | In the unc | leriving cau | se alven ir | Part I. | 24s, WAS AN | AUTOPSY | 248 | . WERE AUTOPSY FINDINGS |
| ICAL | | | | | | | | PERFOR | RMED? | | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| MED | | | | | | | _ | 1 1 123 2 | ZENO | | OF DEATH? |
| ä | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER | 26. PLACE C | F DEATH (C | heck only or | ne) | | | |
| IXSI | 1 YES 2 NO | | ER/Outpetient 3 DOA | 4 🗆 Nursi | ng Home 5 | | _ | | | | |
| | 1 Natural 5 Pending | (Month, De | | JURY M | 28c. INJURY A WORK? 1 YES | | 28d. DE: | SCRIBE HOW I | NJUHY OCC | UHED | |
| D BY | 2 Accident Investigation 3 Suicide 6 Could not b | 28e. PLACE OF | INJURY — At home, farm, rtc. (Specify) | street, facto | | | | ATION (Street | | or Rural | Route Number, |
| | 4 Homicide determined | ballong, | na. (opecny) | | | | City | or Town, State) | | | |
| COMPLETED | | YSICIAN: To the best of | my knowledge, death occur | red at the tir | ne, date and p | lace, and du | e to the car | use(a) and ma | nner as state | id. | |
| ON | one) 2 MEDICAL EXAM | NER: On the basis of ex | amination and/or investigat | ion, in my op | elnion, death o | ccured at th | e time, data | and plece, ar | nd dua to the | cause(| a) and manner as stated. |
| BE | 296. SIGNATUISE AND TURE OF CENTIF | HER ALAM |) | | 29c. | LICENSE NU | MBER | / | 29d. DATE | SIGNE | (Month, Day, Year) |
| 9 | 30. NAME AND ADDRESS OF PERSON Y | WHO COMBI ETED CHIC | S OF DEATH ATTENDED | n Outer | | 107 | 014 | | 12 | 2/8 | /90 |
| | 506 TIDLE | WILN | ARTA | | md | 211 | 1001 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAL | s shorthan | 1 | | - 74 | | | | | |
| | DECTACIAAN | a service | | 1 | | | | | | | |

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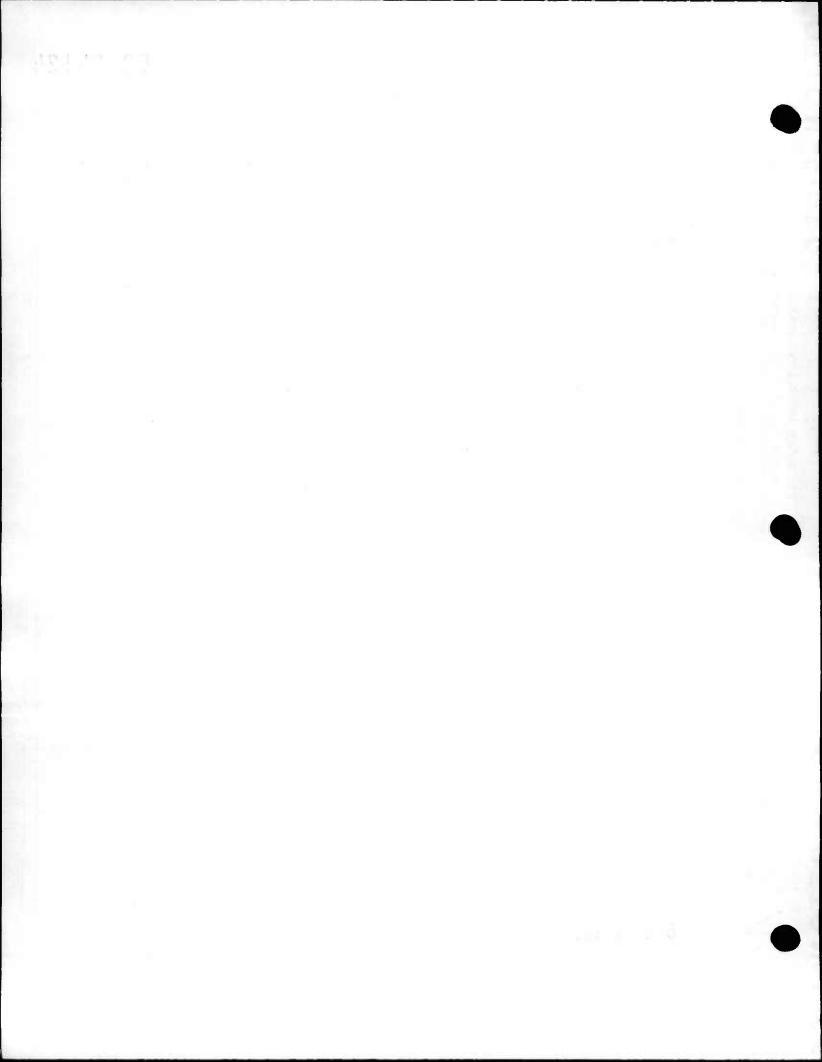
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| BALTIMORE, MARYLAND 21203-3146 | The law requires that the death certificate be executed within drs after death. Page 6 may be retained by the hospital or attending physician. | to serificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
|-------------------------------------|--|---|---|
| N DF VITAL RECORDS, P.O. BOX 13146, | INSICIAN: The law requires that the death certificate be executed within | The mas certificate has been signed by the attending physician and completely filled in by the function with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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TO THE HOSPITCHE LIFE LIFERINGS TO THE FUNERAL DIRECTORS. After the filed within 72 hours after charge many 11 fem 26 fg m.

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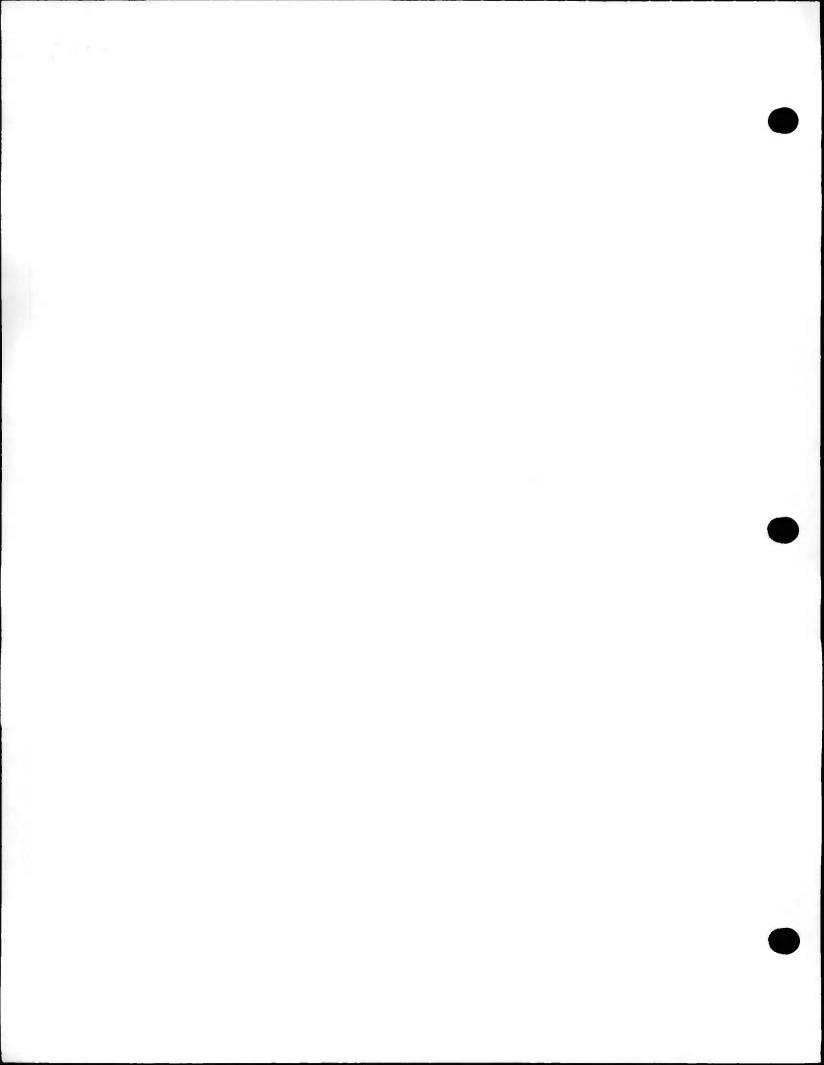
| | FOR STATE REGISTRAR | STATE OF MA | | | | | EALTH AND DEATH | MENT | AL HYGIENI REG. NO. | | | |
|--------------------|---|---|--|---------------------|--|---------------------------|---|---|---|---|-----------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Nancy L. | Patter | son | | | | MON | e of DEATH | 1990 " | AR | 3. TIME OF DEATH |
| | 212-30-2517 | 1 □ M 2√√XF | AGE (In yrs. les | t birthday) YRS. | IF UNDER 1 | DAYS | IF UNDER 24 HRS, HOURS MIN. | Ma Ma | e of BIRTH nth, Day, Year) BY 20,19 | 931 | Ba. | lto. Md. |
| H 1 | 96. FACILITY NAME (If not institution, give etre 400 Stoney Terra | rrace Fallston | | | | | EATH | ec. county of death Harford | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE Maryland Harfo | | | | , TOWN O | TOWN OR LOCATION Fallston | | | | 10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO | | |
| FUNERAL | 10e. STREET AND NUMBER 400 St | | | | 21047 | | | | | NAT COUNTRY? | | |
| ā | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed MX Divorced | 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | | | yes, sp | ENDENT OF HISPA Icity Cuben, Mexico 2 NO Specia | en, Puert | | or No 14. | RACI Bleci Spec | E — American Indian, k, White, atc. Aly: White |
| COMPLEIED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elementery/Secondery (0-12) 12 VIS | ATION ompleted) College (1-4 or 5+) | (G | | vork done d e retired.) | uring mo | etary | | s. KIND OF BUS | | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | 71100. | <u>.</u> u c | 0001 | 18. MOTHER'S NA | | | | _ | - |
| מר | J. H | Mall Aiker | | - MAN INC | ADDRESS | (Chan at a | Agr | | B. Deal | Photo 7in Co | efe l | |
| 2 | Mrs. Ursula D. Ca | llahan | " | | | | Terrace | | | 111111 | 0.00 | 47 |
| | 20e. METHOD OF DISPOSITION 10 Burlel 2 Cremation 3 Remove 4 Denation 5 Other (Specify) | | 20b. PLACE other pl Morel | OF DISPOS | SITION (Nar | ne of cer | netery, crematory or | | 20c. LO | CATION — CITY KVILLE | or To | own, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | | | | ID ADDRESS OF F | | E.F.L | assahr | F | uneral Home |
| | ► E. F. Lassa | | | | | | Belair | | | | _ | |
| | 23. PART I. Enter the diseases, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | ist only one cause | on each line | CA | NCE | | - ME | | | | t, | Approximate Interval Between Onset and Death |
| NO. | Sequentially list conditions, if any, leading to immediate | | UE TO (OR AS A CONSEQUENCE OF): UE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | cause, Entar UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (O | R AS A CONSE | OUENCE OF | F): | | | | | | | |
| | resulting in death) LAST | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant conditions | contributing to d | aath but not | resulting i | In the un | deriyin | g cause given in | Part I. | 24a. WAS AN PERFOR 1 TYES 2 | MED? | 248 | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| S | 25. WAS CASE REFERENCE TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF DEATH (C | heck only | one) | | | |
| באורא | 27. MANNER OF DEATH | 1 Inpatient 2 I E 28e. DATE OF IN (Month, Day) | JURY | 26b, TIM | 4 🗌 Nun | ing Hon 28c. IN. | URY AT | | ther (Specify) DESCRIBE HOW II | NJURY OCCU | RED | |
| à | 1 🗗 Natural 5 📗 Pending 2 🔲 Accident investigation | | | | M 1 YES 2 NO At home, farm, street, factory, office | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | Route Number, | |
| | 290. CERTIFIER 1 E CERTIEVING PHYSIC | IAN: To the heat of m | u knowledne d | ath occum | ad at the ti | me dete | and place, and du | in to the | Causa(a) and man | nor on stated | | |
| COMPLEIED | one) 2 MEDICAL EXAMINER | | | | | | leath occured at th | e time, d | | d due to the o | euse(| |
| TO BE | G Mily and TITLE OF CENTIFIER | Muin | LO | | | | D 38 | JMBER PY9 | 34 | 29d. DATE S | Z / | Month, Say, Year) |
| | Dr. Gregory Kale | mkerian | Johns | | | Hos | .Balto. | Md. | | 955- | 889 | 93 |
| | DEC 1 2 1990 | 20. REGISTRAR | s signature | delle | | | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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| SINC | = | F re | ned |
| + | illed | n, 0 | 9 |
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be fetained by the hospital of attending | TO THE PONERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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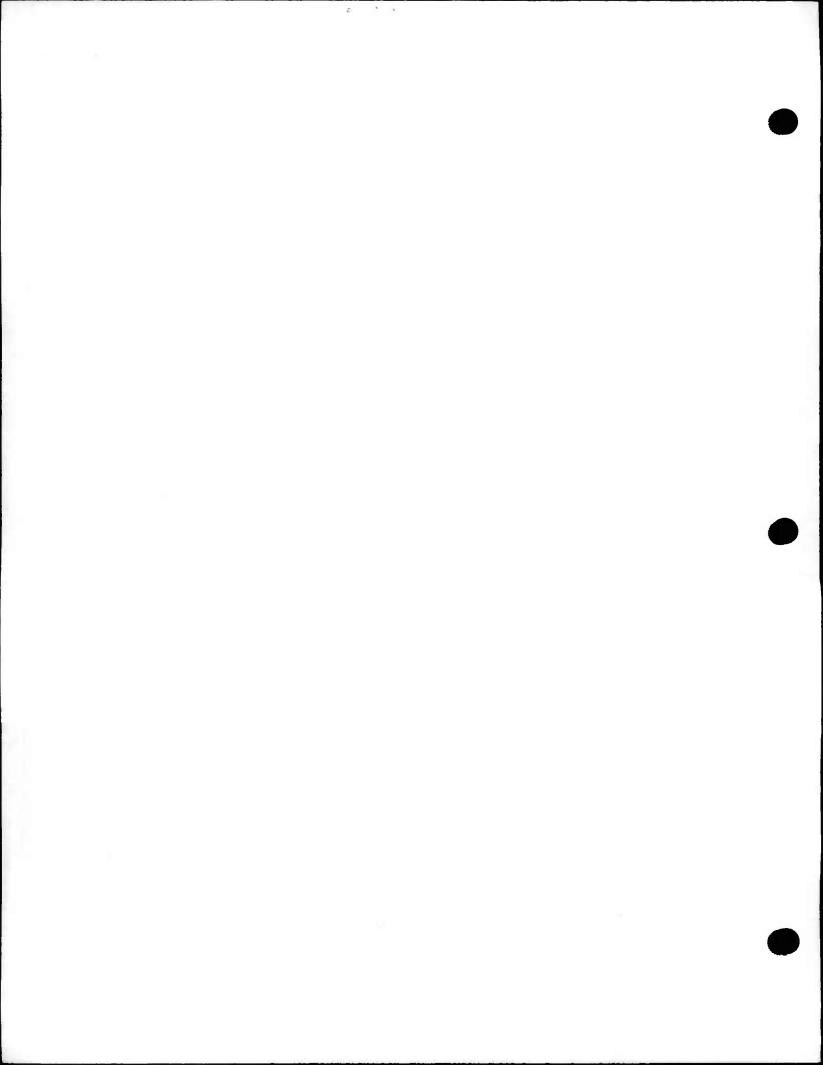
| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | | F HEALTH | | ENTAL HYGIENI REG. NO. | E | |
|--------------------|--|---|-------------------------|------------------------|--------------------|------------|---|---------------|---|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | _ | | | T | 2. DATE OF DEATH MONTH DA | , , | 3. TIME OF DEATH |
| | JERRY | 4 | HOLCA | 16 | | | 12 08 | | 0 2016 Pm |
| | 4. SOCIAL SECURITY NUMBER | 11. | (In yrs. last birthday) | | AR IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| | 215-01-0454 | / | YRS. | | | | Ian. 13, 191 | | Maryland |
| ۱ ـ | 9e. FACILITY NAME (If not institution, give s | | | 7.1137 | wn or Location | | тн | 9c. COUNT | Y OF DEATH |
| 5 | St. AGnes Hospita | . J. | | Di | ATCIMOL | е | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | TY, TOWN OR I | | | | | 10d. INSIDE CITY LIMITS? |
| | Md | | Ва | ltimore | | | - | | 1 K YES 2 NO |
| UNERAL | 100. STREET AND NUMBER | | | 101. ZIP CODE 21230 | | | | | N OF WNAT COUNTRY? |
| N I | 1612 Spence STre | 12. WAS DECEDENT EVER | IN II S ARMED | 13 WAS | | | C ORIGIN? (Specify Yee | U.S. | |
| ם ב | 1 Never Merried 2 Merried 3 X Wildowed 4 Divorced | FORCES? 1 YES | 2 X NO | if yo | | n, Mexican | , Puarto Rican, etc.) | 0110- | t. RACE — American Indien, Black, White, atc. Specify: White |
| 3 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 18e. DECEDENT | S USUAL OCCL | PATION | na | 16b. KIND OF BUS | INESS/INDUS | |
| 9 | Elementery/Secondery (0-12) | College (1-4 or 5+) | | | ng most of working | 9 | | | |
| OMPL | 10th Grade | | Superv | isior | | | Meat Pa | | Plant |
| ا د | 17. FATHER'S NAME (First, Middle, Last) Thomas Polcak | | | | | | E (First, Middle, Meiden Ceoidlova | Surname) | |
| H | 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILIN | IG ADORESS (S | | | oute Number, City or Town | n State Zin C | (ode) |
| 2 | Nancy J. Polcak | | | | | | imore, Md. | | |
| ì | 20e, METHOD OF DISPOSITION 15E Burlel 2 Cremation 3 Rem | 20 | b. PLACE OF DISPO | OSITION (Name | of cemetery, cres | natory or | 20c. LO | CATION — CI | ty or Town, State |
| | 4 Donation 5 Other (Specify) | 1 | Loudon P. | | | | | BAltim | ore |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | // | 22. NA Hu | bard F | uner | al Home Ir | ıc. | |
| | James 1 | 4.20 | // | | | | Avenue, Ba | | |
| 1 | 23. PART I. Enter the disease, or shock, or heart fellure immediate Cause (Final disease or condition resulting in death) | e. EXIENSI | eech line. | | | | ss cardiac or raspi | | Intarval Between |
| | | DUE TO (OR AS | A CONSEQUENCE | OF): | | . va | | | _ |
| 2 | Sequentially list conditions, | b. OUE TO (OR AS | A CONSEQUENCE | | one To |) V 172 | THE P | CULEN | 37. |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | !] |
| | CAUSE (Disease or injury that initiated evente | OUE TO (OR AS | A CONSEQUENCE | OF): | | | | | |
| Ä | resulting in deeth) LAST | d | | | | | | | |
| ای | PART ii. Other eignificent condition | ns contributing to death | but not resulting | g in the unde | rlying cause | givan in i | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | | | 1 TES 2 | | COMPLETION OF CAUSE OF GEATH? |
| BY PHYSICIAN: MEDI | | | | _ | | | _ | <i></i> | 1 _ YES 2 _ NO |
| ÿ | | | | | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | OTHER: | 26. PLACE OF E | 2532 | Control of the same | | |
| | 1 YES 2 NO 27, MANNER OF CEATH | 1 Inpatient 2 ER/Ou | | | g Home 5 R | eeldence | 6 Other (Specily) 28d. DESCRIBE HOW I | NJURY OCCL | JRED |
| 1 | 1 Natural 5 Pending | (Month, Day, Year) | ' | NJURY | WORK? 1 YES 2 | □ NO | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE OF INJUR building, etc. (Sp | RY — At home, ferm | n, atreet, factory | , office | | 28f. LOCATION (Street City or Town, State) | | or Rural Route Number, |
| - | 4 Homicide determined | | | | | | ony or rount, orano, | | |
| COMPLETED | CONSTRUCTION OF THE PROPERTY O | SICIAN: To the best of my kno ER: On the basis of examinat | | | | | | | d. ceuse(e) end menner ee atated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | R | | | 29c, LIC | ENSE NUM | BER | 29d, DATE | SIGNEO (Month, Day, Year) |
| TO BE | ASPECA ST. | HOLD HISPITA | | pe, Print) | | | | ► 12 | 108/90. |
| | DIETHOT AYORL | 32. REGISTRAR'S SIG | HUSPITA | L.901 | CATO | NA | VENUE BA | Moros | 25 mp. 212 |
| | 31. DATE FILED (Month, Day, Year) DFC 1 2 1990 | Julia Davidson | Ander. | | | | | | |
| | | U | | | | | | | DHMH-16 Rev 1/89 |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | DIDENTOR |
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| 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | | | | | |
|---|--|---|----------------------------|--|--|----------|-----------|-------------|--------------------------------------|--------------|---|-------------------|----------------------|----------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | Τ. | | | | | 2. DATE OF I | DAY | 12/8 | /90 YEAR | 3. TIM | E OF DEATH | | |
| | Marie 4. SOCIAL SECURITY NUMBER | M. | | lube | | | | | Dec. | Dec. 9, 1 | | | _E | 9:50pm ₩ | | |
| | 220-22-6343 | 1 M 2 X F | i. AGE (In yrs. lest 84 | YRS. | IF UNDER | DAYS | HOURS | MIN. | 7. DATE OF E (Month, Da Aug 28 | 6 | Count | (State or Foreign | | | | |
| | 9a. FACILITY NAME (If not institution, give s | | 84 | | 9b. CITY, | TOWN O | R LOCATIO | | | 9c. COUNTY | | | Maryland of DEATH | | | |
| O.B. | Stella Maris | | | | Towson | | | | | | Baltimore | | | | | |
| اظ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | Υ | | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | 10d. INSIDE CITY | | | | | |
| E | Maryland Baltimore | | | Parkville | | | | | | | LIMITS? | | | | | |
| A | 10e. STREET AND NUMBER | | | | 101. ZIP CODE | | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | | | |
| FUNERAL DIRECTOR | 2709 Glendale Road | | | 21234 | | | | | 4 | | United States | | | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 X Merried 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 X F | | | O If yes, specify Cuben, Mexicen, Puerlo Ricar | | | | | | | | | | | | |
| À | 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES | | | 1 Tes 2 NO Spec | | | | | у: | | | | Specify: White | | | |
| 9 | 15. OECEOENT'S EDUCATION (Specify only highest grade completed) (Gi | | | | CEDENT'S USUAL OCCUPATION ve kind of work done during most of working Do NOT use retired.) | | | | | | | USINESS/INDUSTRY | | | | |
| | Elementery/Secondery (0-12) | Elementery/Secondary (0-12) College (1-4 or 5+) | | | | | | | | | İ | | | | | |
| COMPLET | 12 17. FATHER'S NAME (First, Middle, Last) | | | ПОП | nemak | er | 18 MOTH | ED'S NAM | E (First, Midd | lo Maiden S | Sumamal | | | | | |
| | Herman | | Rolfes | | | | 10. 10.11 | | Aanes | re, maider d | Botorek | | | | | |
|) BE | TOTAL | | | | | | | or Rural Ro | oute Number, (| City or Town | , State, Zi | | | | | |
| 2 | Bernard M. Rut | oeling | | | 9 Gl | | | | Balti | | _ | | 2123 | | | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremetion 3 Rem | novat from State | 20b. PLACE (| ce) | | | | | 00 | | | City or To | | | | |
| 1 | | | | | | | y 12 | | | Bd | | | ore, Maryland | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE MILTON J Knight | | | | Ur. 2123 | | | | | | | | Harford Road | | | |
| | 23. PART I. Entar the diseases, or | complications that | caused the day | ath. Do | | | | | | | | | | Approximata | | |
| | shock, or heart failure. IMMEDIATE CAUSE (Final | List only one caus | e Dn aach lina | Δ | | | | | | | | ,, | - 1 | ntarval Between | | |
| | disease Dr condition resulting in death) | a. | Cer | el | ml | tra | scul | 070 | cc | dei | 1 | | İ | | | |
| | | DUE TO (C | OR AS A CONSEC | UENCE O | F): | 1 | 1. | 2 | | | | | | | | |
| ON | Sequentially list conditions, | ebrol bascolor accident erebrol hemorrage | | | | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | UENCE OF): | | | | | | | | | | | | | |
| E | that initiated events resulting in dasth) LAST | UENCE O | | | | | | | | | | | | | | |
| 5 | d | | | | | | | | | | | | | | | |
| CAL | PART II. Other significant condition | ns contributing to d | eath but not r | sulting | In the un | dariying | g causa g | lven in P | Part J. 24 | n. WAS AN / | | 248 | | AUTOPSY FINDINGS BLE PRIOR TO | | |
| | | | | | | | | | _ 1 | YES 2 | | | | ETION OF CAUSE | | |
| ME | | | | | | | | | - | | | | 1 🗆 1 | ES 2 NO | | |
| AN | 25, WAS CASE REFERRED TO MEDICAL | | | | | 26 PI | ACE OF DE | FATH (Chec | ck only one) | | | | | | | |
| PHYSICIAN: MEDI | EXAMINER? | HOSPITAL: | ER/Outpetient 3 | □ DOA | OTHER 4 W Num | ₹: | | | Other (S | pecify) | | | | | | |
| ¥ | 27. MANNER OF DEATH | 28e. DATE OF II (Month, Day | | 28b. TIR | - | 28c. INJ | URY AT | - | 28d. DESCRI | | JURY O | CCURED | | | | |
| BY | 1 Natural 5 Pending Investigation | | M 1 Tes 2 No | | | | | | | | | | | | | |
| | 3 Suicide 8 Could not be determined 28e. PLACE OF INJURY — At hom building, etc. (Specify) | | | | ne, ferm, atreet, factory, office 28f. LOCATION City or To | | | | | | N (Street and Number or Rural Route Number, wn, State) | | | | | |
| | 29a CEDTIEIED . | | | | | | | | | | | | | | | |
| COMPLETED | (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner se stated. EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(s) end menner as stated. | | | | | | | | | | | | nenner as stated. | | | |
| | 296. SIGNATURE AND TITLE Of CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | | | |
| 3 BE | Deffrey | a Com | My | 1 | | | Do | 341 | 250 | | • | 12 | 110 | 192 | | |
| 5 | 1000 land | HO COMPLETED CAUSE | OF DEATH (THE | 1 27) (Typ | o, Print) | 30 | L. C | Tud. | 217 | 34 | | | | 1 / 1 | | |
| | 31. DATE FILED (Month, Day, Year) | | | - | · / | ince | NP | , 000 | -/ 6 | /_ | | | | | | |
| | DFC 121 | 990 Julia | S PGNATURE: | Mano | - | 5.7 | | | | | | | | | | |
| | 320 | | | | - | | | | | | | | | | | |

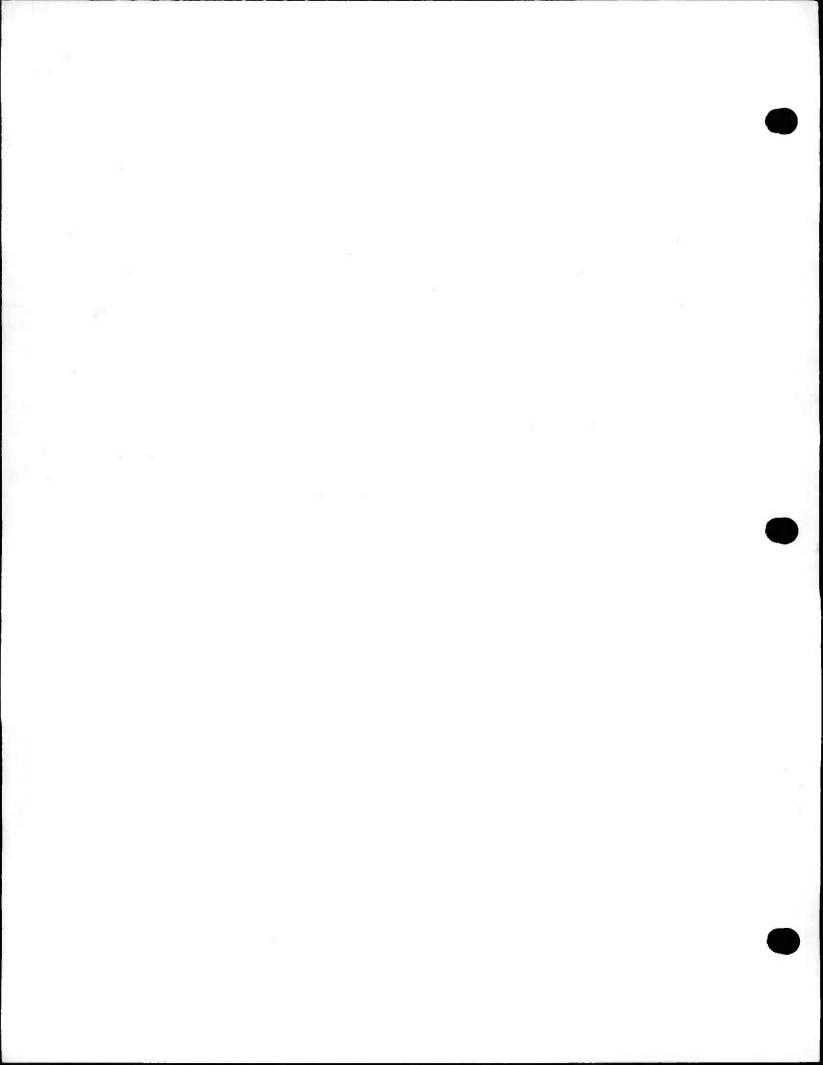


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| L: The law cate has be State Dept. | IAN: The law requires that the death certificate be executed within 2 mous after death. Page 6 may be retained by the hospital or attending physician. | tificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | ie State Dept. of Health and Memtal Hyglene prior to burlat, cremation, or removal, | or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|------------------------------------|--|--|---|---|
| 5 = " | IN: The law requires that the d | ficate has been signed by the | State Dept. of Health and Mei | item 23 shows any injur |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

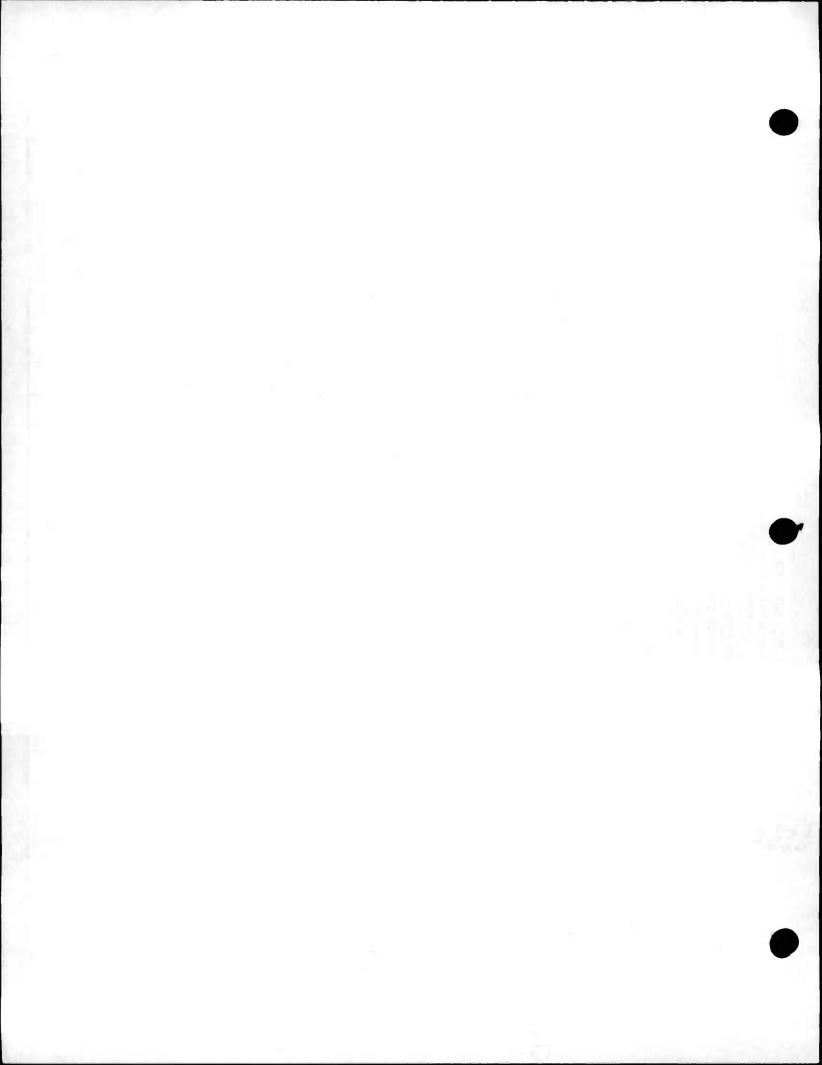
| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | |
| | ETTA WALTERS RILEY 2. DATE OF DEATH MONTH DAY YEAR 1.5 PM | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Inst birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Fordan | | | | | | | | | |
| | 217-52-3398 1 M 2 F 93 YRS. MONTHS DAYS HOURS MIN. 5-21-97 Country) | | | | | | | | | |
| | 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | |
| œ | | | | | | | | | | |
| 2 | ST AGNES HOSPITAL BACTIMORE / | | | | | | | | | |
| ပ္ပ | 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | |
| <u>E</u> | MD BALTIMORE 1 VES 2 KNO | | | | | | | | | |
| 51 | | | | | | | | | | |
| ₹ | | | | | | | | | | |
| 9 | 5008 LEAR HUENUE 21224 USA | | | | | | | | | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yea, specify Culput, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, If yea, specify Culput, Mexican, Puerto Rican, etc.) | | | | | | | | | |
| ВУ | 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 Ves, specify: Upon, Mexicen, Puerto Hican, etc.) 1 Ves, specify: Upon, Mexicen, Puerto Hican, etc.) Specify: Upon, Mexicen, Puerto Hican, etc.) | | | | | | | | | |
| | \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | | | | | | | | | |
| 田 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | | | | | | | | | |
| Ë | Elementary/Secondary (0-12) College (1-4 or 5 +) ille. Do MOT use retired.) | | | | | | | | | |
| ₹ | Elementary/Secondary (0-12) College (1-4 or 5+) Housew. Fe House | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | |
| BE | Howard M. Koyer Margaretta Walters | | | | | | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street end Number or Rural/Floute Number, City or Town, State, Zip Code) | | | | | | | | | |
| 2 | EHa R. Riley 5008 Ceder Ave, Ba Himore MD. 21227 | | | | | | | | | |
| | 20c. METHOD OF DISPOSITION (Name of cemetery, cremetery, cremetery or 20c. LOCATION — City or Town, State | | | | | | | | | |
| | 1 Suriel 2 Cremation 3 Removal from States other place) 4 Denetion 5 Other (Specify) Meadow Branch Cem Westminster, MD | | | | | | | | | |
| | 21. BIGHATURE OF FUNEBAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY;) | | | | | | | | | |
| - 1 | Haward H. Hussara Inc. | | | | | | | | | |
| | Fever Hickunk 4107 Wilkens Ave, Bultimore 40.21229 | | | | | | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardisc or respiretory errest, Approximate | | | | | | | | | |
| | ahock, or hasrt failure. List only one cause on asch ifna. interval Batween Onset and Death | | | | | | | | | |
| | disease or condition | | | | | | | | | |
| | resulting in dasth) a. Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | - N/A | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| 2 | CAUSE (Disease or injury | | | | | | | | | |
| Ē | that initiated events requiring in dasth) LAST | | | | | | | | | |
| Ä | d. | | | | | | | | | |
| | PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | |
| EDICAL | PERFORMED? AMULABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | |
| 0 | 1 YES 2 NO OF DEATH? | | | | | | | | | |
| Σ | 1 YES 2 NO | | | | | | | | | |
| Ž | | | | | | | | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | | |
| S | 1 VES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH 280. DATE OF INJURY (Month, Day, Year) 280. TIME OF INJURY AT UNDER HOW INJURY OCCURED INJURY WORK? | | | | | | | | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation M 1 YES 2 NO | | | | | | | | | |
| | 3 Suicide S Could not be 28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, tectory, office City or Town. State) | | | | | | | | | |
| E | 4 Homicide determined | | | | | | | | | |
| Ш | 29e. CERTIFIER | | | | | | | | | |
| COMPLETED | (Check only CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(e) end menner se stated. | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occured at the time, date end place, end due to the ceuse(a) and menner se stated. | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| | manha Carmondo madred water & | | | | | | | | | |
| 0 8 | Many ruminde medical wedner 12-10-90 | | | | | | | | | |
| TO B | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H agnes Hogy tal - 9D Cuton and Bulto 212)9 | | | | | | | | | |



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| | FOR STATE REGISTRAR | STATE OF N | MARYLAND / | DEPAR | TMENT OF | HEALTH AND | MENTAL HYGIEN | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | | 3. TIME OF DEATH |
| | All | rr D | OSE | | | | 12 0 | | 90 | 09:15P M |
| | ELLA 4. SOCIAL SECURITY NUMBER | H. K | 6. AGE (In yrs. lest | A fast at a co | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | / 19 T | | PLACE (State or Foreign |
| | 4. SOCIAL SECONITY NUMBER | | | | MONTHS DAYS | 1 | (Month, Day, Year) | | Country |) |
| | 237-06-7436 | 1 🗆 M 2 📈 | 88 | YRS. | | 1000 | 03-04-19 | 02 | No | . Carolina |
| - 1 | 9a. FACILITY NAME (If not institution, give s | treet and number) | | | 9b. CITY, TOW | OR LOCATION OF O | EATH | 9c. COUN | ITY OF DE | EATH |
| 5 | GREATER BALTIMO | RE MEDIC | AL CENTE | ZR | , | owson | | BALT | IMOR | E |
| DIRECTOR | RESIDENCE OF DECEDENT | THE HEDIO | TILD OBIVITE | | | 111111111111111111111111111111111111111 | | 12122 | | |
| W | 10s. STATE 10b. COUNTY | r | | 10c. CIT | Y, TOWN OR LO | CATION | | | | 10d. INSIDE CITY LIMITS? |
| ā | Maryland | Balto. | | | White H | all | | | | 1 NES 2 NO |
| 4 | 10e. STREET AND NUMBER | | | | | 101. ZIP CODE | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| FUNERAL | 2310 McComas | Rd. | | | | 2116 | 51 | 11 | S.A. | |
| Z | 11. MARITAL STATUS | 12. WAS DECEDEN | IT EVER IN U.S. ARI | MEO | 13. WAS D | | NIC ORIGIN? (Specify Yes | | | Americen Indien, White, etc. |
| | 1 Never Merried 2 Merried | FORCES? 1 | ☐ YES 2 ☑ N | 10 | If yea, | spectfy Cuben, Mexico | an, Puerto Rican, etc.) | | | |
| B | 3 🔯 Widowed 4 🗌 Divorced | IF YES, GIVE Y | MAH OH DATES | | '''' | ES 2 NO Specif | ry: | | Specif | |
| | 15. DECEDENT'S EDU | CATION | 16a, DE | CEDENT'S | USUAL OCCUP | TION | 16b. KIND OF BU | SINESS/IND | USTRY | White |
| E | (Specify only highest grade | | (Gi | ve kind of Do NOT u | work done during ise retired.) | most of working | 3,44,44,4 | | | 1 |
| 7 | Elementary/Secondary (0-12) | College (1-4 or 5 | +1 | | maker | | | Home | | 1 |
| COMPLETED | 6 | | | - | | 1 | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S N | AME (First, Middle, Maiden | Surname) | | |
| B | James W. Ho | lland | | | | Anni | e Selle | ers | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | 198 | . MAILIN | ADDRESS (Stre | et and Number or Rural | Route Number, City or Tow | vn. State, Zip | Code) | |
| - | Mrg Etnoctino | Chambers | | | same a | s10e | | | | |
| | 200. METHOD OF DISPOSITION | | 20b. PLACE other pla | OF OISPO | SITION (Name of | cemetery, cremetory or | 20c. LC | CATION - | City or To | wn, State |
| | 1 Buriel 2 Scremation 3 Rem | Tom state | 10.00 | | ht Ceme | etery 12 | /10/90 | Balt | o. M | d. |
| - 4 | 21. SIGNATURE OF HUNERAL SERVICE LI | DENBER / | 77 | | 22. NAME | ANO ADDRESS OF F | ACILITY | | | |
| , j | N/ 11/6" 1 | 1.1.1 | V. | | | | 1050 | York | Rd. | 21204 |
| | Mould (- Ac | CAPU AC | e: | | | | uneral Hom | _ | | |
| | 23. PART i. Enter the diseases, or shock, or heart fallure. | complications the | et caused the de | eth. Do | not enter the | mode of dying, su | ch as cerdiec or reep | iretory en | rest, | Approximete interval Between |
| | IMMEDIATE CAUSE (Final | Dist only one ca | ose on sach line | 10 | | | | | | Onset and Death |
| ΙΥ | disease or condition | ד זווא | ISYSTEM | ORG | AN FATT | IRF | | | | 48 HRS. |
| | reaulting in death) | | O (OR AS A CONSE | | | OKE | | | | 40 IIKb. |
| | INCARCERATED HIATAL HERNIA: SEVERE HYPOVOLEMIA | | | | | | | | | |
| Ó | Sequentielly list conditions, | DUE TO | O (OR AS A CONSE | DUENCE (| NIAL IIL | MIA. SEV | EKE HIFOVO | LEMIE | 7 | + |
| A | if any, leading to immediate cause. Enter UNDERLYING | SEVE | ERE LIMB | TSCI | нгмтΔ | | | | | |
| 윤 | CAUSE (Disease or Injury that initiated events | <u> </u> | OR AS A CONSE | | | | | | - | + |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| 点 | | d | | | | | | | | |
| 1 - | PART II. Other aignificant condition | ns contributing to | death but not r | resulting | in the underl | ing ceuse given in | | | 246. | WERE AUTOPSY FINDINGS |
| EDICAL | | | | | | | | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | 1 TYES | Z [] NO | | OF DEATH? |
| ≥ : | | | | | | | | | | 1 TYES 2 NO |
| SICIAN: | | | | | | | | | | |
| ठ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | PLACE OF OEATH (C | Check only one) | | | |
| S | 1 D YES 2 DNO | | ☐ ER/Outpatient 3 | □ DOA | | fome 5 - Residence | 8 Other (Specify) | | | |
| T. MANNER OF DEATH 28a. DATE OF INJURY (Month, Dey, Year) 28b. TIME OF INJURY AT WORK? 1 Neturat 5 Pending Investigation 2 Accident 3 Suicide 6 Could not be 28b. PLACE OF INJURY At home, farm, street, factory, office 28b. LOCATION (Street en building, etc. (Specify) 28b. DATE OF INJURY 28c. INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 1 YES 2 NO 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? 28c. INJURY AT WORK? | | | | | | | | INJURY OC | CURED | |
| | | | | | | | | | | |
| | | | | | | | | end Numbe | r or Rural F | Route Number, |
| l w | 4 Homicide determined | bunung | , etc. (Opeciny) | | | | Only or Jown, State | " | | |
| LET | 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the heat | of my knowledge 4 | anth annu | read at the time- | tete and place and d | ue to the cause(s) end m | anner en ch | tad | |
| COMPL | (Critick Orlly | | | | | | | | | e) end manner as stated. |
| 8 | | | | | , | | | | | |
| BE | 296 SHAMATURE AND STILE OF CENTIFIC | R | ~ | | | 29c. LICENSE N | UMBER | | | (Month, Day, Year) |
| 0 | Stan 10 Bella | 11022 | -MD | | | | | 1 | 410 | 190 |
| 100 | Of NAME AND ADDRESS OF PERSON W | HO COMPLETED CA | USE OF DEATH (TE | M 27) (7/2 | ne. Print) | | | | | |

| Investigation | | T TES 2 NO | | | | |
|---------------------------|--|---|-------|---|--|--|
| 6 Could not be determined | 28e. PLACE OF INJURY — At home, farm, street, facto building, etc. (Specify) | 28f. LOCATION (Street end Number or Rural Route Number, City or Town, State) | | | | |
| | i: To the best of my knowledge, death occurred at the ti in the basis of examination end/or investigation, in my o | | | | | |
| SELALA | less MD | 29c. LICENSE NU | MBER | 29d. DATE SIGNED (Month, Day, Year) 12/10/90 | | |
| MESS OF PERSON WHO CO | OMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | |
| ohn B Bigh | ardgen M.D. 1205 Yo | rk Rd. | 21093 | | | |
| C 1 2 1990 | 32. JEGITRAL SIGNATURE THAT AND THE STATE OF | | | | | |
| | | | | DHMH-18 Rev 1/8 | | |

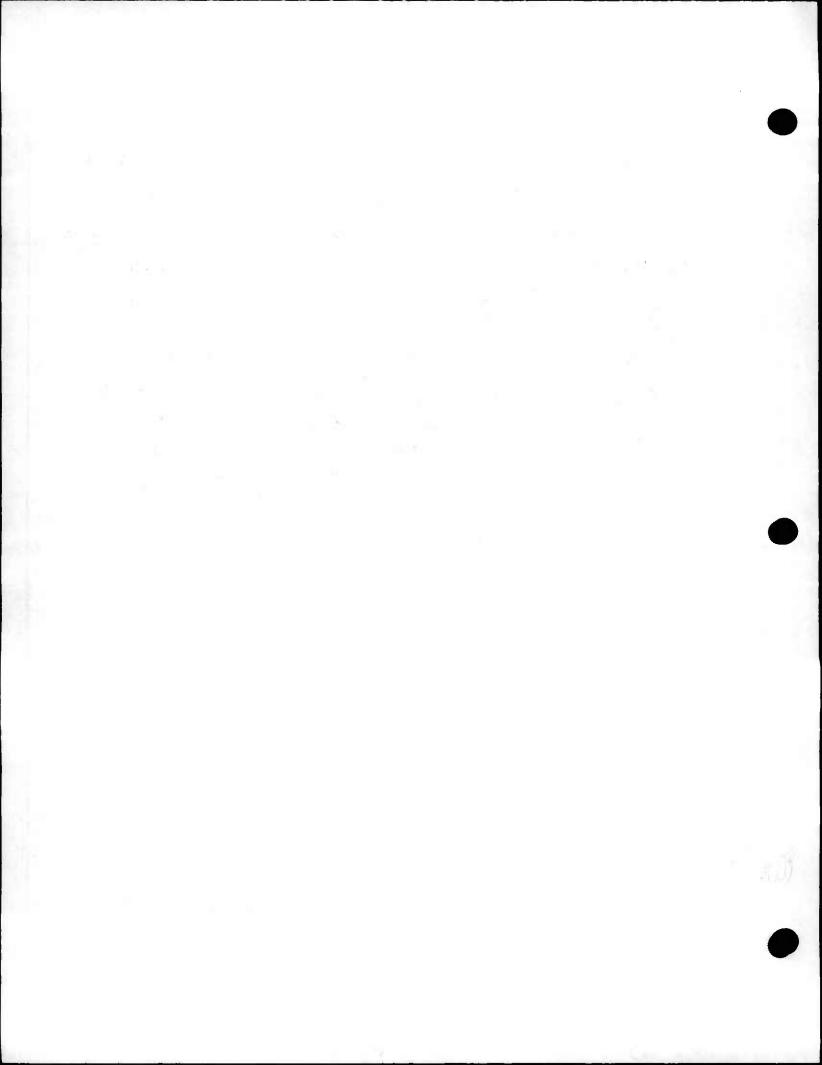


BALTIMORE, MARYLAND 21203-3146

WISION OF VITAL RECORDS, P.O. BOX 13146,

RECTOR: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should the state Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. ATENDING PHYSICIAN: The law requires that the death certificate be executed within 2., nours after death. Page 6 may be retained by the hospital or attending physician. them 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1 - STATE OF MARYLAND REGISTRAR | | MENT OF H | | MENTAL HYGIENI REG. NO. | | 04125 | | | |
|---------------|--|-------------------------------|--|-----------------------------|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) ENE D. RHODUS | | | | 2. DATE OF OEATH MONTH 12-4-90 | Y YEAR | 3. TIME OF DEATH 10:55AM M | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. In 12 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | 7. DATE OF BIRTH 8-4-40 | 8. BH | RTHPLACE (State or Foreign unity) IINOIS | | | | |
| FOR | 90. FACILITY NAME (If not Institution, give street and number) Behind 60 W. Timonium Road RESIDENCE OF DECEMENT | | 9b. CITY, TOWN O | R LOCATION OF DE | АТН | Balti | more County | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY Maryland Carroll | | kesville | | | 10d. INSIDE CITY LIMITS? 1 U YES 2 X NO | | | | |
| FUNERAL | 7403 Village Rd. | | 101. ZIP CODE 21784 | | | 10g. CITIZEN OF WHAT CO | | | | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. 4 FORCES? 1 YES 2 FORCES? IF YES, GIVE WAR OR DATES | RMED NO | If yes, spe | | IIC ORIGIN? (Specify Yee n, Puerto Rican, etc.) | ee or No— 14. RACE — American Indian, Black, White, etc. White | | | | |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) | Give kind of wife. Do NOT use | USUAL OCCUPATION or done during mode retired.) | DN st of working | 16b. KIND OF BUS | | Y | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | 7 41 | 16. MOTHER'S NA | ME (First, Middle, Maiden | | | | | |
| BE | Riley Rhodus | | | Mathile | | Nale | | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Mathilde Rhodus | | | | Route Number, City or Town | | | | | |
| | 20e. METHOD OF DISPOSITION 20b. PLAC | E OF DISPOS | | netery, cremetory or | or Town, State Md. | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc, 1050 York Rd. Towson, Md. 21204 | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the | | | | | | Approximate | | | |
| | ahock, or heart failure. List only one ceuse on each if IMMEDIATE CAUSE (Final disease or condition resulting in death) Arteriosclery | otic o | | scular d | isease | | Onset and Death | | | |
| Z | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CATIC | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | |
| A | PART II. Other aignificent conditions contributing to death but no | t resulting i | in the underlyin | g cause given in | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | |
| MEDIC | · · · · · · · · · · · · · · · · · · · | | | | MXXES 2 | 1117 | COMPLETION OF CAUSE OF DEATH? | | | |
| . ME | | | | | | 1 | NO 2 □ NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | LACE DF DEATH (C) | heck only one) | | | | | |
| YSI | YES 2 NO 1 inpatient 2 ER/Outpatient | _ | | | a XiX ther (Specify) | Scene | | | | |
| ВУ РН | 27. MANNER OF DEATH XXX Netural 5 Pending 2 Accident Investigation | | M 1 🗆 | JURY AT ORK? YES 2 NO | 28d. DEŞCRIBE HOW | | | | | |
| | 3 Suicide 8 Could not be determined 28. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify) 28. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 2 MRDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated. | | | | | | | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CHITTEEN | 1 | 1 | 29c. LICENSE NU OCME | | | 2-5-90 | | | |
| L | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (I MARIO F. GOLLE, JR., MD | | 111 Pen | n Street | ,Baltimore | ,MD 212 | 201 vo | | | |
| | 31. DATE FILED (MONTH; Day, 1864) DFC 1 2 1990 Julia Davidson | Randal | E | | | | | | | |



permit. Pages 1, 2, 3 should

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| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🗻 nours after death. Page 6 may be retained by the hospital o | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for he stand with the State Deer, of Health and Mental Hogiere prior to burial, cremation, or removal. | IMPORTANT; If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| od withi | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furble find within the State Debt, of Health and Mental Hypiene prior to burial, cremation, or removal. | event |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DAY MONTH 12 90 8 William Charles Ruxton 4:21 A. 5. SEX 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH 8. BIRTNPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. (Month, Day, Year) 2-14-55 DAYS 35 HOURS 1 X M 2 | F 213-52-7287 YRS. Mary 1 and 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATN 9c. COUNTY OF DEATH DIRECTOR 26 S. Exeter Street Baltimore RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Baltimore Towson 1 ☐ YES 2 ☐ NO 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10s. STREET AND NUMBER 10f. ZIP CODE 1900 Eastland Rd. 21204 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puarto Rican, atc.)

1 YES 2 NO Specify:

Specify: 1- Never Married 2 Marrie IF YES GIVE WAR OR DATES BY 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high ring most of working (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) /Secondary (0-12) 1 2yrs COMPL Landscaper Landscaping 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) John C. Ruxton Virginia BE 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 John C. Ruxton 1900 Eastland Rd. Towson, Md. 21204 20a. METHOD OF DISPOSITION
1 ☐ Burlal 2 ☐ Cramation 3 ☐ Ramoval from State 20b. PLACE OF DISPOSITION (Name of cometery, cramatory or 20c. LOCATION — City or Town, State Green Mount Baltimore, Md. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23. PART i. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximete shock, or heart failure. List only one cause on each line. interval Between Onset and Death **IMMEDIATE CAUSE (Final** disease or condition Gunshot Wound of Chest resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AVAILABLE PRIOR TO COMPLETION OF CAUSE COMPLETIO OF DEATH? 17 YES 2 | NO Y YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) OTHER: 1 X YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 ☐ Nursing Nome 5 ☐ Residence Š(XOther (Specify) scene 6 27. MANNER OF DEATN 26d. OEŞCRIBE HOW INJURY OCCURED 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? marked, 1 Natural 5 Pending 12-8-90 4:13 A. 1 YES subject was shot BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28 Is 6 Could not be determined COMPLETED 4 3 Homicide lobby of building 26 S. Exeter St., Balto. Md. **FANT: If Item** 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of axa mination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated. ATURE AND TITLE OF CEL 29b. SIGN 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 12-8-90 OCME 2

> 32 REGISTERA'S SIGNATOR ANGLE 2 DHMH-16 Rev 1/89

111 Penn St., Balto., Md.

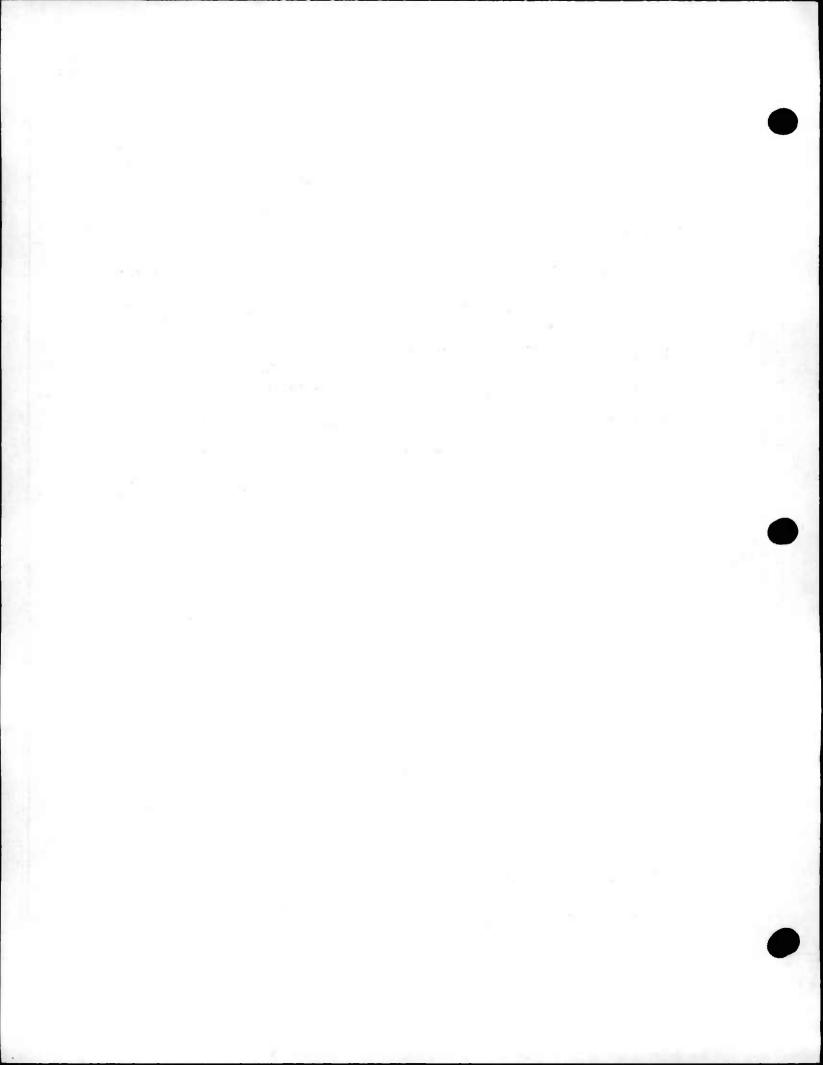
21201

O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

M.D.

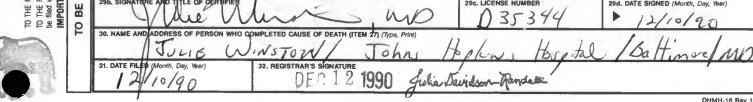
Ann M. Dixon,

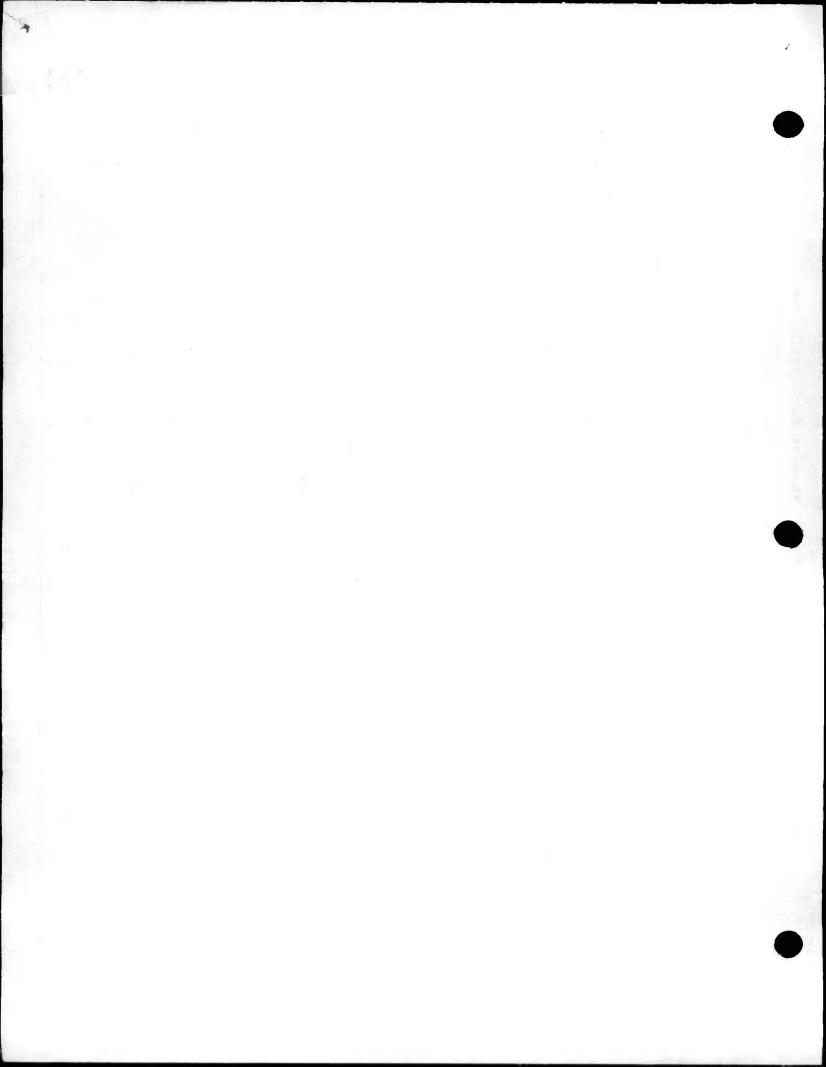
31. DATE FILED (Month, Day, Year) " "



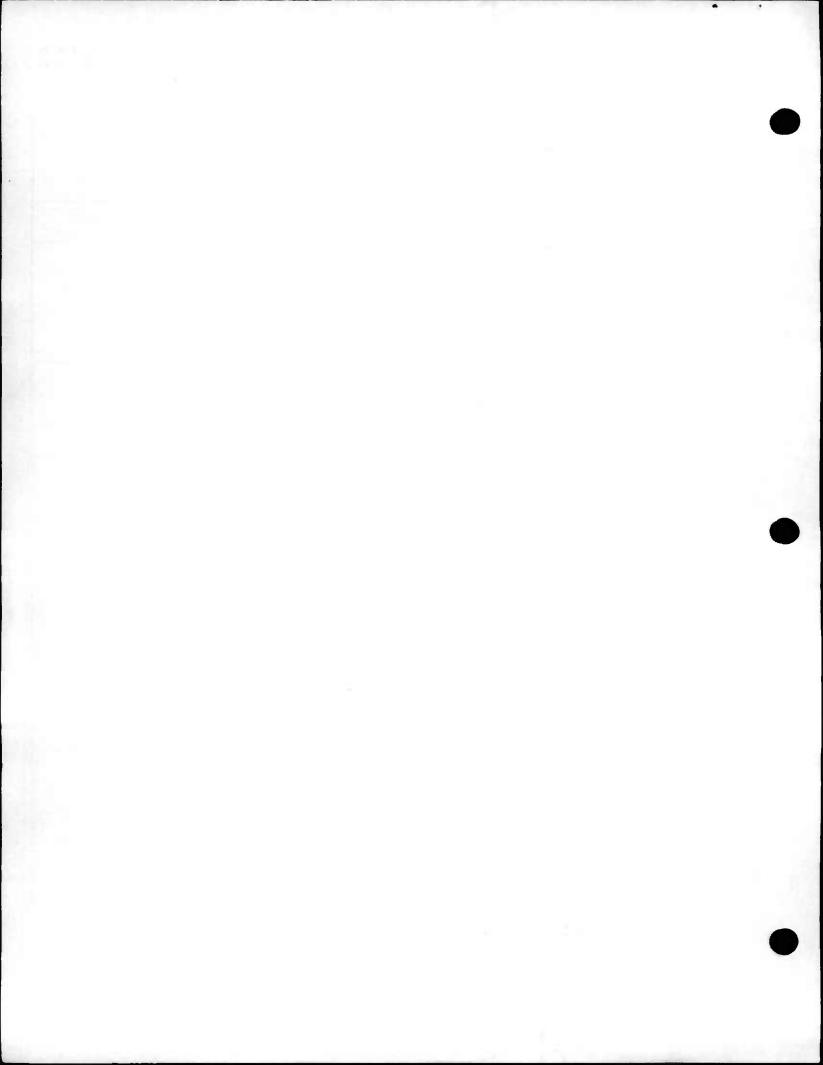
BALTIMORE, MARYLAND 21203-3146

| | FOR STATE REGISTRAR | STATE OF M | | | RTMENT OF | HEALTH AND DEATH | MENT | AL HYGIEN REG. NO. | | 90 | 34131 |
|----------------------|--|--|-----------------------|--------------------------------|--|--|---------------------|---|-------------------------|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) FREDERICK T. RUS | SH | | | | | DEC | EMBER DA | " 10 | | or death 9:50 a.m. |
| | 4. SOCIAL SECURITY NUMBER 222-01-1693-A | 5. SEX | 6. AGE (In yrs. In 80 | ast birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DAT (Mo JU | E OF BIRTH Inth, Day, Year) LY 12 1 | 910 | Country) | CE (State or Foreign |
| TOR | 96. FACILITY NAME (If not institution, give : THE JOHNS HOP! | The state of the s | PITAL | - | | OR LOCATION OF D | EATH | | 9c. COUN | TY OF DEAT | н |
| DIRECTOR | MD . | KENT | | 10c, CIT | KENNED | VVILLE | | | | | d. INSIDE CITY LIMITS? X YES 2 \(\text{NO}\) |
| FUNERAL | 100. STREET AND NUMBER 101 BELCHESTE | | | | | 01. ZIP CODE 21645 | i | | υ. | S.A. | |
| BY FU | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES ZX | | If yee, | CENDENT OF HISPA specify Cuben, Mexico S 2 NO Specif | en, Puarl | | or No— | Specify: | American Indian, hite, etc. |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | | | (Give kind of ife. Do NOT u | B USUAL OCCUPA work done during is se retired.) D MASTE | nost of working | .t | 66. KIND OF BUS | SINESS/IND | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) FREDERICK O. | RUSH | | | | 18. MOTHER'S NA | | t, Middle, Maiden A. HER | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) JOSEPH A. RUSH | (SON) | | 75 | COMMONW | and Number or Rural EALTH BLV | D., | new CA | n, State, Zip .STLE, | Code) DELA | . 19720 |
| | 20e. METHOD OF DISPOSITION 1 | | | | | | | | | | |
| | 21. SIGNATURE OF JUNETAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOME INC. 3331 Brehms Lane, Baltimore, Md. 21213 | | | | | | | | | | |
| | 23. PAST I. Enter the diseases, or complications that caused the desth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) e. Peval (#5:3/ | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): Location Consequence of the cons | | | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significant conditions contributing to deeth but not resulting in the undarlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| HYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | | | | | | | | | | |
| ED BY | 1_Netural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE (building | | | | VORK? YES 2 NO | 28f. L | OCATION (Street Otly or Town, State) | end Number | | e Number, |
| COMPLET | (Orlock Orly) | SICIAN: To the best of | | | | | | | | | nd manner as stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | THO COMPLETED CAL | ISE OF BEATU II | > 0 | WD . | D 35 | JMBER 3 9 | 14 | 29d. DAT | | orth, Day, Year) |





| | | | | | | 9 | 0 34132 | |
|-----------------------|--|--|---|--|--|---|---|--|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | T OF HEALTH AND E OF DEATH | MENTAL HYGIE REG. N | | | |
| | | 1. SHORTER | | | 2. DATE OF DEATH MONTH 12209 | | 3. TIME OF OEATH | |
| | 4. SOCIAL SECURITY NUMBER 214-40-6717 | 6. SEX 6. AGE (In yra | | R 1 YEAR IF UNDER 24 HRS. DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Ybar) 10-14- | -09 | BIRTHPLACE (State or Foreign Country) | |
| OB | 9a. FACILITY NAME (If not institution, give at MERIDIAN ME | DICAL CENTER | 9b. CIT | BALTIMORE, | | 9c. COUNTY | OF DEATH | |
| RAL DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 1 | 10c. CITY, TOWN | OR LOCATION TIMORE. CI | TV | 10d. INSIDE CITY LIMITS? 1 √ / VES 2 □ NO | | |
| | 10e. STREET AND NUMBER 922 E. 43rd | STDEET | 1 DAL | 101. ZIP CODE | | OF WHAT COUNTRY? | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 X Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | ARMED 13 | 2 1 2 1 2 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | RACE American Indian, Black, Whita, atc. Specify: BLACK | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) 4 y r S | DECEDENT'S USUAL (Give kind of work done life. Do NOT use retired. TEACHER | during most of working | 21411000 000 | O . CIT | Y SCHOOLS | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | 18. MOTHER'S NAME (First, Middle, Malden Surrame) FDNA HAWKINS | | | | |
| 2 | WILLIAM I. | 1721 LA | SS (Street and Number or Rural KESIDE AVE | IORE, N | | | | |
| | 20b. METHOD OF DISPOSITION 1 & Burlet 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or BMC Place) I MORE NATIONAL CEM. BALTIMORE, MD. 21. SIGNATURE OF DISPOSITION (Name of cemetery, crematory or BMC Place) I MORE NATIONAL CEM. BALTIMORE, MD. | | | | | | | |
| | Vonne | 1. 1. Zen | 1 | | | 101 E. | NORTH AVE. | |
| | 23. PART Lenter the diseases, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on each | line. | the mode of dying, such decimals and the mode of dying, such decimals are the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying, such as the mode of dying are the mode o | | apiratory arrest | Approximate interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A COM | perference pp: | - | | | 3-4 decad | |
| PHYSICIAN: MEDICAL CE | PART II. Other significant condition | ns contributing to death but n | inderlying cause given in | PERF | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ОТНІ | 26. PLACE OF DEATH (C | heck only one) | | <u> </u> | |
| PHYSI | 1 YES 2 THIQ 27. MANNER OF DEATH | 1 ☐ Inpatient 2 ☐ ER/Outpatier 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF | ursing Home 5 - Residence 28c. INJURY AT WORK? | 6 Other (Specify) 28d. DESCRIBE HO | W INJURY OCCUP | RED | |
| BY | Natural 5 Pending | Suicide Suic | | | | | Rural Route Number, | |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | ICIAN: To the best of my knowledge. | | | | | | |
| BE | 296, SIGNATURE AND TITLE OF CERTIFIE TO An Mu | | | 29c. LICENSE NU | | 29d. DATE S | IGNED (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | 10 COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print) | | | 1 | 1 | |
| | DEC 1 2 1990 | 32. AEGISTRAB'S SIGNATU | RS Amdall | | | | | |

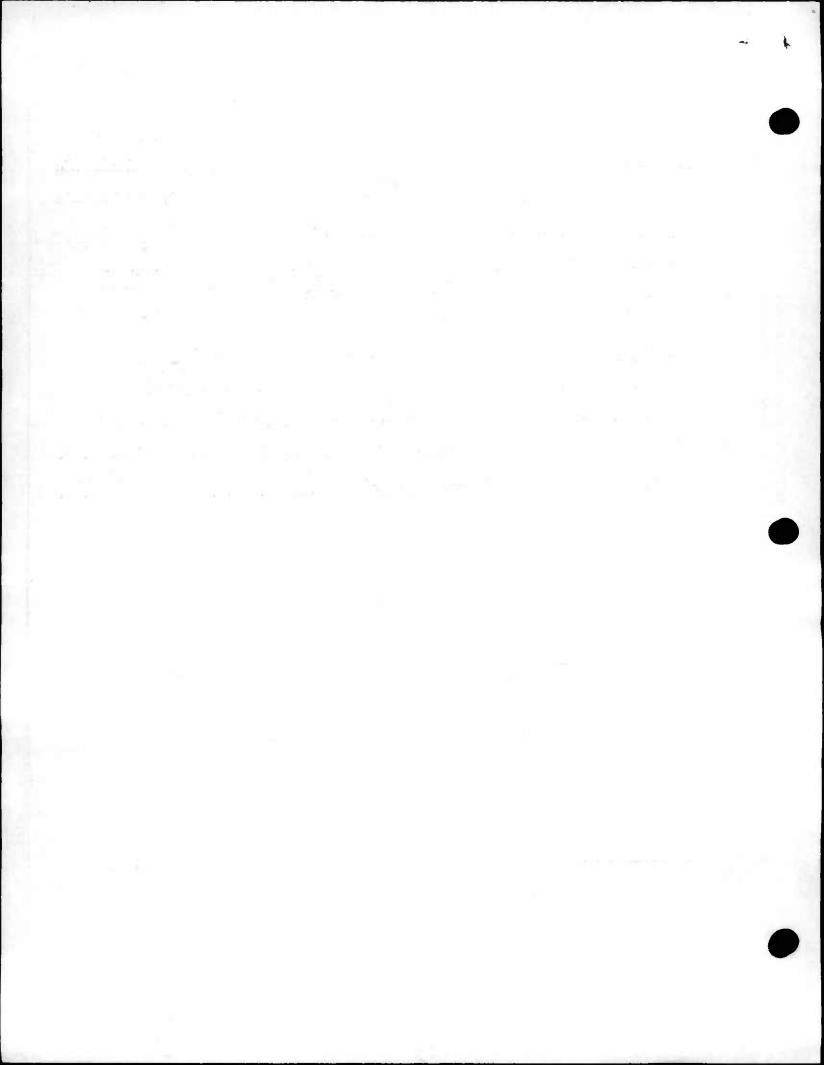


TO BE COMPLETED BY FUNERAL DIRECTOR

| TO BE COMPLETE | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|---|---|
| examiner must be notified at once. | IMPORTANT: Il lieft 26 is market, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 how's after that the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
| he funeral director, page 5 should be detached for use | TO THE FUNERAL DIRECTOR AND CONTROL OF SHOULD BE SHOUND BE SHOUND BE SHOUND BE SHOUND BE SHOUND BE GREACHED FOR USE |
| er death. Page 6 may be retained by the hospital or att | TO THE HOSPITAL OR ATTER OF THE PARTICIAN: The law requires that the death certificate be executed within 10 10 att |

who Davidson-Randale

| FOR | | | | | 2 | |
|---|--|--|--|--|-----------------|--|
| 1 _ STATE | STATE OF MARYL | | WENT OF HEALTH AND | | E | |
| REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | CERTIFIC | ATE OF DEATH | REG. NO. | | 3. TIME OF DEATH |
| ROSE | SHERMAN | | | DECEMBER | | A |
| 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | F UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. B | RTHPLACE (State or Foreign |
| 152-38-0058 9a. FACILITY NAME (If not institution, give st | 1 □ M 2√Q F | 77 YRS. MC | DAYS HOURS MIN. | | | iladelphia |
| PRINCE GEORGE'S H | | | | CAIR | | |
| RESIDENCE OF DECEDENT | OSPITAL CEN | ICK | CHEVERLY | | PRINC | E GEORGE'S |
| New Jersey Atl | | | town or Location Lantic City | - | 100 | 10d. INSIDE CITY LIMITS? XX YES 2 \(\square\) NO |
| 10s. STREET AND NUMBER | | | 101. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 101 North Raleigh | | | 08401 | | u. s | . A. |
| 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed XX Divorced | 12. WAS DECEDENT EVER I FORCES? 1 _ YES IF YES, GIVE WAR OR D | N U.S. ARMED NO DATES | 13. WAS OECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 NO Spec | an, Puerto Rican, etc.) | | RACE — American Indien, Black, White, etc. Specify: White |
| 15. OECEDENT'S EOUG (Specify only highest grade | CATION | 16a. OECEDENT'S US | SUAL OCCUPATION to done during most of worlding | 16b. KIND OF BUS | SINESS/INOUST | |
| Elementary/Secondery (0-12) | College (1-4 or 5+) | Iffe. Do NOT use i | retired.) | | | |
| 12 Years | | Sal | les Lady | Retai | l Candy | |
| 17. FATHER'S NAME (First, Middle, Last) Kople Shore | | | | AME (First, Middle, Maiden | | |
| | | | | Sophie (Unl | | |
| 1901. INFORMANT'S NAME (Type/Print) Edwin J. Roth | | | OORESS (Street and Number or Rura | | | |
| 200. METHOD OF DISPOSITION | | | cific Avenue, | | CATION - CITY | |
| 1) Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | other place) | ilah Cometeru | PROG | ıxantvi | PPO N T |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | 22. NAME AND ADDRESS OF P. D.M. STEIN HE | ACILITY ΣΩΕία ΙΙΓΙΙΛΏΩ: | | TRAL HAUF |
| Oonald (| Xtot | themuje | 232 CARROLL S | T. N.W. | UASHTNG | TON D C |
| IMMEDIATE CAUSE (Finel disease or condition | Liet only one ceuse on a | each line. | t anter the mode or dying, au | ch ea cerdlac or reap | iratory errest, | Approximate interval Batwaen Onset and Deeth |
| resulting in death) | |) | | | | 1 |
| | DUE TO (OR AS | A CONSEQUENCE OF): | | | | |
| | DUE TO (OA AS | 4 | | | | |
| Sequentially list conditions, | b. Phe | A CONSEQUENCE OF): | | | | |
| If any, leading to immediate cause. Enter UNDERLYING | b. Predom South | A CONSEQUENCE OF): | | | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Predom South | A CONSEQUENCE OF): | | | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | b. Predom South | A CONSEQUENCE OF): | | | | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Due to (or as c. Due to (or as d. | A CONSEQUENCE OF): | | n Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. | A CONSEQUENCE OF): | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. | A CONSEQUENCE OF): | | | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. | A CONSEQUENCE OF): | | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition Chemo Th | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS | A CONSEQUENCE OF): | | PERFOI | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition Chemo TR | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. | A CONSEQUENCE OF): A OONSEQUENCE OF): but not resulting in | the underlying ceuse given i | PERFOI 1 VES : | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition Chemo Th | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. HOSPITAL: Inpetient 2 ER/Out | A CONSEQUENCE OF): A OONSEQUENCE OF): but not resulting in | 26. PLACE OF DEATH (COTHER: Nursing Home 5 Residence OF 28c. INJURY AT | PERFOI 1 VES : | PMED? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition Chemo // 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | DUE TO (OR AS DUE TO (OR AS d. HOSPITAL: 11 Inpatient 2 ER/Out | A CONSEQUENCE OF): A OONSEQUENCE OF): but not resulting in | 26. PLACE OF DEATH (COTHER: Nursing Home 5 Residence OF 28c. INJURY AT | PERFOI 1 YES : Check only one) | PMED? | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition Chemo R 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending | DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. HOSPITAL: 10 Inpatient 2 ER/Out 28e. DATE OF INJURY (Month, Dey, Year) | A CONSEQUENCE OF): A CONSEQUENCE OF): A CONSEQUENCE OF): but not resulting in tention 3 DOA CONSEQUENCE OF): | 28. PLACE OF DEATH (COTHER: Nursing Home 5 Residence OF | PERFOI 1 YES : Check only one) | INJURY OCCURI | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition Chemo / R 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (OR A | A CONSEQUENCE OF): A OONSEQUENCE OF): but not resulting in tpertient 3 □ DOA 14 28b. TIME INJUITY — At home, ferm, streedhy) | 28. PLACE OF DEATH (COTHER: Nursing Home 5 Residence OF | Check only one) 8 Other (Specify) 28d. OESCRIBE HOW 28t. LOCATION (Street City or Town, State) | INJURY OCCURI | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO No EO Rural Route Number, |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant condition Chemo / R 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR AS C. DUE TO (OR AS d. DUE TO (OR A | A CONSEQUENCE OF: A CONSEQUENCE | the underlying ceuse given is 26. PLACE OF DEATH (COTTHER: 6 Nursing Home 5 Residence OF 28c, INJURY AT WORK? 1 YES 2 NO reet, factory, office is at the time, date end piece, end did, in my opinion, death occured at the second course of the second cou | PERFOI Tell PERFOI Tell | and Number or F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, Duse(e) end manner as stated. SINEO (Month, Day, Year) |
| H any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINI 29b. SIGNATURE AND TITLE OF CERTIFIE | DUE TO (OR AS C. DUE TO (OR AS d. DUE TO (OR A | A CONSEQUENCE OF: A CONSEQUENCE | 26. PLACE OF DEATH (COTHER: 6 Nursing Home 5 Residence OF 26c. INJURY AT WORK? 1 YES 2 NO reet, factory, office at the time, date end piece, end de, in my opinion, death occurred at the time of the country of the co | PERFOI Tell PERFOI Tell | and Number or F | AMALABLE PIRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Rural Route Number, Duse(e) end manner as stated. SINEO (Month, Day, Year) |



1 - FOR STATE REGISTRAR

| 13146, |
|----------|
| BOX |
| , P.O. |
| RECORDS, |
| VITAL |
| NO NC |
| DIVISION |
| |

| | | 1. DECEOENT'S NAME (First, | | CJ - CW | LSIE | J. STE | DMAN | | | 2. DATE | OF DEATH DAY | Y | YEAR 3 | TIME OF OEATH |
|---|---------------|--|-----------------------------------|--|--------------------------|---------------------------------|---------------|-----------|-------------------|-------------|-------------------------------|-------------|------------------|---|
| | | 4. SOCIAL SECURITY NUMB | | | GE (In yrs. las | st birthday) # | F UNDER 1 YEA | IR IF | UNDER 24 HRS. | 7. DATE | F BIRTH | 2 | 6. BIRTHPL | ACE (State or Foreign |
| _ 1 | | 212-34-7677 | | 1 🗆 M 2 🗸 F | 96 | - | ONTHS DAY | | OURS MIN. | Mghyl. | Day year | ic/ | Mary] | CONTRACTOR CONTRACTOR |
| pinous | | 90. FACILITY NAME (# pot in | | et and number) | 7.0 | | b. CITY, TOW | /N OR LO | OCATION OF DE | ATH | | | NTY OF DEA | тн |
| 2, 3 | TOR | Saint JOS | seph- | Hospital | | | TOUR | on | MI | <u> </u> | | Ba | Him | ore |
| iges 1. | DIRECTOR | 10e. STATE | 10b. COUNTY | | | 10c. CITY, 1 | OWN OR LO | CATION | | | | | 10 | 0d. INSIDE CITY LIMITS? |
| | | Maryland 100. STREET AND NUMBER | Balt | imore | | Ba1 | timor | | | | | | | ☐ YES 25(3KNO |
| sit per | RAI | 1328 Heathe | r Hill | Rd. | | | | | 239 | | | | S.A. | AT COUNTRY? |
| burial-transit permit. Pages | FUNERAL | 11, MARITAL STATUS | | 12. WAS DECEDENT EVE FORCES? 1 Y | | | | DECEND | DENT OF HISPAN | | | | 14. RACE - | - American Indian, White, atc. |
| he bu | ВУ Б | 1 Never Married 2 3 Widowed 4 Divo | | IF YES, GIVE WAR O | | | | | NO Specify | | mount, actory | - 1 | Specify: Whit | |
| se as the | ED | 15. DEC | EDENT'S EDUCA highest grade of | ATION omoleted) | 18e. Di | ECEDENT'S US | UAL OCCUP | ATION | f working | 16b. | KINO OF BUS | SINESS/INC | | |
| d for use | COMPLET | Elementary/Secondary (0 | 1 | College (1-4 or 5+) | life | n <i>Do NOT use n</i> memake | etired.) | | | 0. | n Home | _ | | |
| detache | OMF | 17. FATHER'S NAME (First, M | iddle, Last) | | 110 | шешаке | : L | 18. | B. MOTHER'S NAI | | | | | |
| d be d | ш | Mathie Macz | is | _ | | | | | Augusta | a Zie | dler | | | |
| 5 should be detached notified at once. | TO B | Arthur G. S | | Tan | 19 | | | | Number or Rural F | | | | | 10 |
| page 5 | | 20a METHOD OF DISPOSIT | ION | | Top. PLACE | | | | Hill Ro | 1., h | | | City or Town | |
| rector, page must be | | 1X Buriel 2 Crematic | (Specify) | | other p | daca) | | | ery 12/ | /10/9 | | | - | |
| in by the funeral director, page removal. | | 21. SIGNATURE OF FUNERA | L SHIPPICE LIGH | prijex / | 8 | | | | OWSON I | | al Hor | me.] | Inc. | |
| the fur val. | | Mark | sell | Al De | | | 105 | 0 Y | ork Rd | ., To | wson, | Md. | 21204 | + |
| | | 23. PART i. Enter the d ahock, or h | iseasea, or co aart failure. L | propilications that cause of the cause of th | sed tha d n aach lin | aath. Do not a. | antar tha | moda | of dying, auci | h aa card | llac or reapl | retory ar | reat, | Approximata interval Batween |
| y filled ation, or the m | } | iMMEDIATE CAUSE (Fir disease or condition | nai di | RESPI | PAT | TAP4 | (- | F | AILL | INF | _ | | | Onset and Daath |
| mpletely fille, cremation, | | reaulting in death) | | DUE TO (OR | AS A CONSE | OUENCE OF) | | | | | | | | |
| ending physician and completely fille I Hygiene prior to burial, cremation, or other traumatic event, the | NO | Sequentially list condit | | DUE TO (OR | AS A CONSE | OUENCE OF): | | | | | | | | |
| ysician prior to | CATI | if any, laading to imma cause, Entar UNDERLY CAUSE (Disease or Inju | ING | | | , | | | | | | | | |
| the attending physician Mental Hygiene prior to njury, or other traun | CERTIFICATION | that initiated events resulting in death) LAS | | DUE TO (OR | AS A CONSE | EOUENCE OF): | | | | | | | | |
| | CER | | d | | | | | | | | | | | + |
| ned by the att ith and Menta any Injury, | CAL | PART II. Other aignifica | ent conditions | contributing to das | th but not | reauiting in | tha undar | lying ca | ause glyen in | Part i. | 24a. WAS AN PERFOR | RMED? | I A | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE |
| n signed by the Health and In | MEDICAL | | | | | | | | | - | 1 TYES 2 | ON [| 9 | OF DEATH? |
| as been Dept. of 23 sho | 1 T. I | | | | | | | | | | | | | |
| this certificate has been with the State Dept. of riked, or item 23 sho | HYSICIAN | 25. WAS CASE REFERRED T EXAMINER? | O MEOICAL | HOSPITAL: | | | 2 OTHER: | 6. PLACI | E OF DEATH (Ch | eck only or | 10) | | | |
| certific the S | HYS | 1 TYES 2 NO 27. MANNER OF DEATH | | 1 Inpatient 2 ER/ | RY | 28b. TIME | OF 26c | . INJURY | | | CRIBE NOW I | NJURY OC | CCURED | |
| fter this eath with | ВУ Р | 1 Neturel 5 2 Accident | Pending Investigation | (Month, Day, Ye | ear) | INJUF | | WORKS | | | | | | |
| 4 0 m | 60 | • C • 1111 | Could not be determined | 26e. PLACE OF IN. building, etc. | IURY — At h (Specify) | ome, farm, str | eet, factory, | office | | | ATION (Street or Town, Stete) | | er or Rural Ro | ute Number, |
| DIRECTOR: After hours after death item 28 is ma | ᇤ | 29e. CERTIFIER | TIEVING BHVEIG | MAN: To the heat of my l | nowledge d | taath assumed | et the time | data and | d place, and due | to the se | uno(a) and ma | | eted | |
| 2 7 2 = | COMPL | one) 2 MEC | DICAL EXAMINER | CAN: To the best of my I | | | | on, deatl | h occured at the | time, date | | nd due to t | the ceuse(s) | |
| TO THE FUNERA TO THE FUNERA De filed within 7 IMPORTANT: | TO BE | 29b. SIGNATURE AND TITLE 29b. SIGNATURE AND TITLE 30, NAME AND ADDRESS O | las | COMPLETÉD CAUSE O | r Death dr | F84 070 /5 0 | Audus) | 25 | D 25 | BER B | 86 | 29d. DA | 12 | G 90, |
| | | CEBALI | 05, | M.D. | - 5 | ST. | 20C | E | PH | HO. | SPIT | 4(. | - Tol | NSON MD |
| | | 31. DATE FILED (Month, Day, | 1000 | 32. REGISTRAR'S | SIGNATURE | LARC. | | | | | | | | 21204 |
| E well | | UEC 14 | 1330 | 0 | • | | | | | | | | | DHMH-16 Rev 1/89 |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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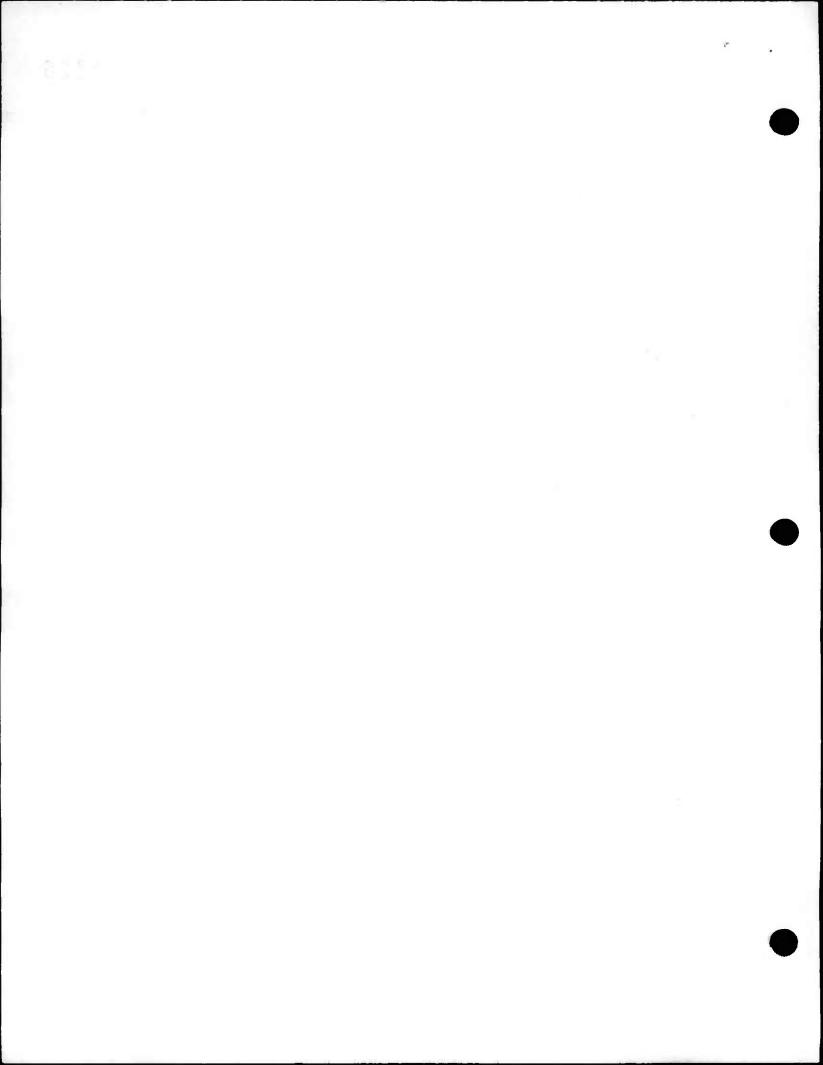
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DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be fined within 72 hours after death with the State Deot, of Health and Mental Hydiene prior to burial, cremation, or removal. | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|
| TO THE HOSPITAL OR ATTENDING PHYS | TO THE FUNERAL DIRECTOR: After this the filed within 72 hours after death with | IMPORTANT: If Item 28 is marked |

| | FOR 1 - STATE REGISTRAR | STATE OF MARY | (LAND / DEPARTM CERTIFICA | | | NTAL HYGIEN | E | |
|------------------|--|--|---|---------------------------|--|---|----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1100 | WARD TRESS | SR. | 2. | DATE OF DEATH EO | 2. 10 19 YEAR | 330 AM M |
| | 4. SOCIAL SECURITY NUMBER 216-09-8329 | 5. SEX 6. A4 1 | 86 YRS. MON | UNDER 1 YEAR ITHS DAYS | HOURS MIN. | DATE OF BIRTH (Month, Day, Year) (ARCH 31 | Cou | RTHPLACE (State or Foreign unitry) MD . |
| TOR | 9a. FACILITY NAME (If not institution, give UNION MEMORIAL I RESIDENCE OF DECEDENT | | | ALTIMO | R LOCATION OF DEATH | H | MARYLA | |
| FUNERAL DIRECTOR | 10s. STATE 10b. COUNT | 17 | | WN OR LOCATE | | | | 10d. INSIDE CITY LIMITS? 1 🔀 YES 2 🗌 NO |
| | 100. STREET AND NUMBER 618 MONTPELLI | ER ST. | | 101. | ZIP CODE 21218 | | U.S. | F WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 YES, GIVE WAR O | ES 2 NO | If yes, spe | ENDENT OF HISPANIC city Cuban, Mexican, F 2 NO Specify: | | 96 | ACE — American Indian, lack, White, atc. |
| COMPLETED | 15. DECEDENT'S ED (Specify only highest grace Elementary/Secondary (0-12) | College (1-4 or 5+) | 16a. OECEOENT'S USU (Give kind of work life. Do NOT use rel | done during mos ired.) | t of working | 16b, KINO OF BUS | | RTIN CO. |
| | N/A 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | N/A | ELECTRONIC | S TECH | 18. MOTHER'S NAME | | | XIIN CO. |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) EDWARD F. TRESS, | JR. | | | ELLIER ST | | n, State, Zip Code) 218 | 9 |
| | 20e. METHOD OF DISPOSITION 1 | | 28b. PLACE OF DISPOSITION other place) MORELA | ND MEMO | ORIAL PARK | В. | CATION — CHY OF ALTIMOR | |
| | 21. SIGNATURÉ OF FUNEIVAL DEPIVICE L | The state of the | Eh. | SCHI | o adoress of facili MUNEK FUNE Brehms La | ERAL HOME | | Md. 21213 |
| | 23. PART i. Enter the disease, or shock, or heert fellure IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | e. CARO | sed the death. Do not a feet line. | | de of dying, such a | s cerdiac or reepi | ratory arrest, | Approximate interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR) | AS A CONSEQUENCE OF): | | | | | |
| MEDICAL | PART II. Other significant condition | MyCLOMA | 7.1 | he undarlying | cause given in Pa | rt I. 24e. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINOINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | ACE OF DEATH (Check | A | | |
| ву рну | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | - | er) INJURY | M 1 🗆 1 | RK? 'ES 2 NO | 8d. OEŞCRIBE HOW | NJURY OCCURED | |
| | 4 Homicide detarmined | 3 Suicide 8 Could not be 28e. PLACE OF INJURY — At home, farm, atreet, factory, office 28t, LO | | | | | and Number or Ru | ral Route Number, |
| COMPLETED | toriook omy | SICIAN: To the best of my k | | | | | | se(s) and manner as stated. |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIF | now MD | | | 29c. LICENSE NUMBI | ER | 29d. DATE SIGN | NED (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PERSON V | phu UN | BUIM WEND | | Hospith | ž. | | |
| | DEC 1 2 1000 | 32. REGISTRAR'S | - Handelle | | | | | |



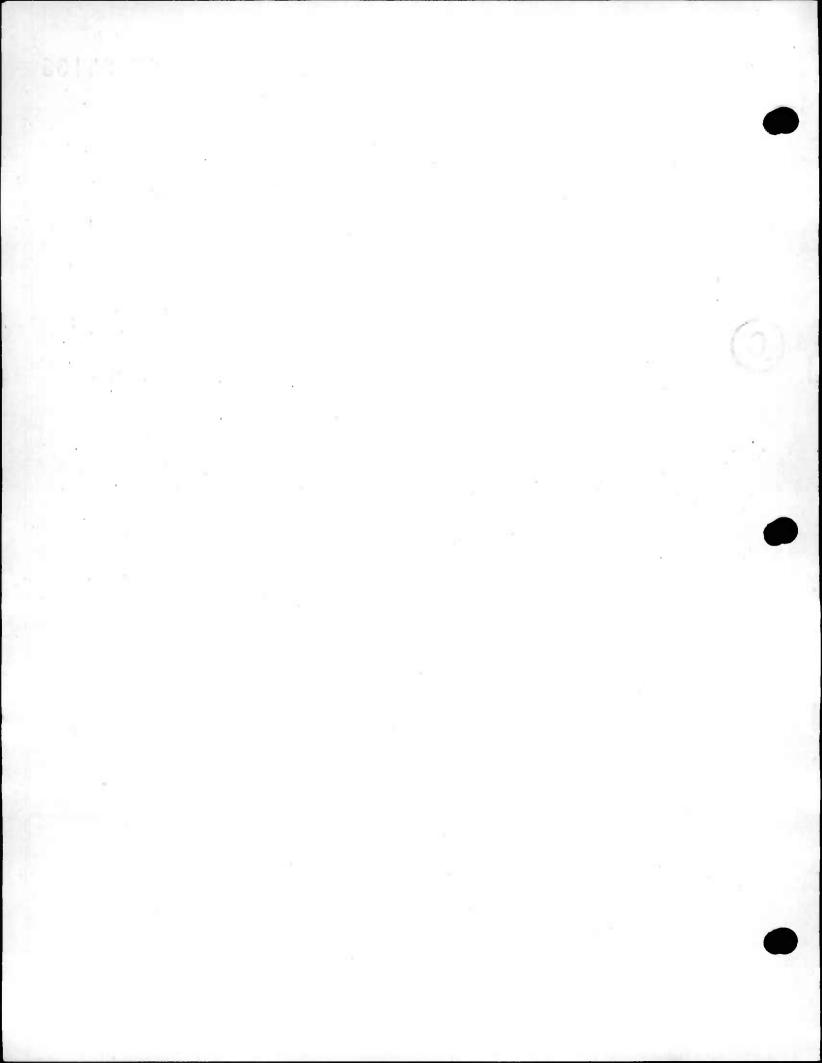


TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAN iours after death. Page 6 may be remined by in TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a victor safer death. Page 6 may be remained by the THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 amount he field within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTI | | | | GIENE G. NO. | 0 09100 |
|--|--|--|--------------------------------|--|--|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) WALTER | | | TRAV | | 2. DATE OF DEA | ATH | S. TIME OF DEATH |
| | 5. SEX 6. AGE (in yrs. | No. | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIR (Month, Day,) 2 - 13 - | TH 8. | BIRTHPLACE (State or Foreign Country) Penna |
| 9e. FACILITY NAME (If not institution, give street PENINSULA GENER. | a de out | 9 | | BURY, MD | EATH | | OF DEATH |
| 10e. STATE 10b. COUNTY MD Wi | comico | 10c. CITY, 1 | TOWN OR LOCA | FION | В | erlin | 10d, INSIDE CITY LIMITS? 1 YES 2 NO |
| 106.STREET AND NUMBER 10510 Racetra | ck Road | | J. | 2 1811 | | | N OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | ARMED NO | If yes, as 1 — YES | CENDENT OF HISPAI ecity Cuben, Mexics 2 NO Specifi | n, Puerto Ricen, e | | BACE — American Indian, Black, White, atc. Specify: White |
| | College (1-4 or 5+) | DECEDENT'S US (Give kind of wor life. Do NOT use i | rk done during me retired.) | ost of working | | of Business/INDUS | TRY |
| 11 years 17. FATNER'S NAME (First, Middle, Last) Walter R. Trav | | renanc | , Mari | | ME (First, Middle, I | Maiden Sumame) | |
| 19a. INFORMANT'S NAME (Type/Print) Bernadette Tra | | | | and Number or Rural | Route Number, City | or Town, State, Zip Co | |
| 20e. METHOD OF DISPOSITION 1 | 20b. PLAC | | | metery, crematory or | | oc. LOCATION — Cit | |
| 21. SIGNATURE OF FUNERAL SERVICE LICES | Ronald Was | de,Dir | | | | E ANATO | MY BOARD 21201 |
| IMMEDIATE CAUSE (Final | pulcations that caused the let only one cause on each if the control of the cause on each if the control of the cause on each if the cause on each if the cause o | Ine. YUCA SEOUENCE OF): | indial | | | reapiratory arres | t, Approximata Interval Between Onset and Death |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avents resulting in death) LAST | DUE TO (OR AS A CONS | | | | | | |
| PART II. Other algorificant conditiona | contributing to death but no trial libilia ling france | | the underlyin | g cause given in | Р | MAS AN AUTOPSY ERFORMED? YES 2 \(\text{NO}\) | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO |
| | HOSPITAL: | | OTHER: | LACE OF DEATH (C) | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 ER/Outpatient 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIME (| OF 28c. IN | NO 5 Realdence | | HOW INJURY OCCU | RED |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicida determined | 28e. PLACE OF INJURY — At building, atc. (Specify) | home, farm, atro | eet, factory, offic | in . | 281. LOCATION City or Town | (Street and Number or), State) | Rural Route Number, |
| ane) | IAN: To the best of my knowledge, | | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER | Jennich, M | D. | | 29c. LICENSE NU | 384 | 29d. DATE 8 | SIGNED (Month, Day, Year) |
| RODNEY A. | WENRICH | | | T. SA | LISBU | RY M | d. 21801 |
| DECL 21990 | 32 REGISTRAR'S SIGNATURE | ander | 1 | | | | |



BALTIMORE, MARYLAND 21203-3146

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DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TAL OR ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physic | LINE COR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat- | if fied within 72 hours, after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Bom 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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31. DATE BLED (Month, Day, Year) 1990

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF GEATH 3. TIME OF DEATH YEAR Anna M. Wilson 12 90 4 SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 93 DAYS 1 🗆 M 2 💢 F 213-74-7205 6-4-97 West Va. 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Inns of Evergreen Balto. 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Md. 1 YES 2 NO Balto FUNERAL 10e. STREET AND NUMBER 10t, ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? 21206

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No—If yee, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 □ YES 2 ☒ NO Specify: 5835 Belair Rd **USA** 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Merried Specify: White ВҰ 3 XWidowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 18b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade completed) rina most of working (Give kind of work done du life. Do NOT use retired.) Elementery/Secondery (0-12) College (1-4 or 5+) Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) BE Patrick Unknown 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Glenamoy Rd. #102 Timonium, Priscilla R. Wilson Md. 21093 20a METHOD OF DISPOSITION

1 → Burlet 2 □ Cremetion 3 □ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION - City or Town, State Pinegrove 4 Donetion 5 Other (Specify) Cemetery Parkton, Md 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY John C. Miller Inc. 6415 Belair Rd. Balto.. Md. 23. PART i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Batwaan **Onaat and Daath IMMEDIATE CAUSE (Final** diseasa or condition OUE TO (OR AS A CONSEQUENCE OF): reaulting in death) ASCVA CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated evants reauiting in daath) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24e. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 00 Ventue 1 YES 2 NO OF DEATH? 1 🗌 YES 2 🗌 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) 1 YES 2 NO HOSPITAL: OTHER: 1 Inpatient 2 ER/Outpetient 3 DOA ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF OEATH 28e. DATE OF INJURY 28b, TIME OF 26c. INJURY AT WORK? 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident INJURY 5 Pending tovestigation 1 YES 2 NO ВҰ 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide 29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner ee stated. (Check only one) MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) end menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 01979

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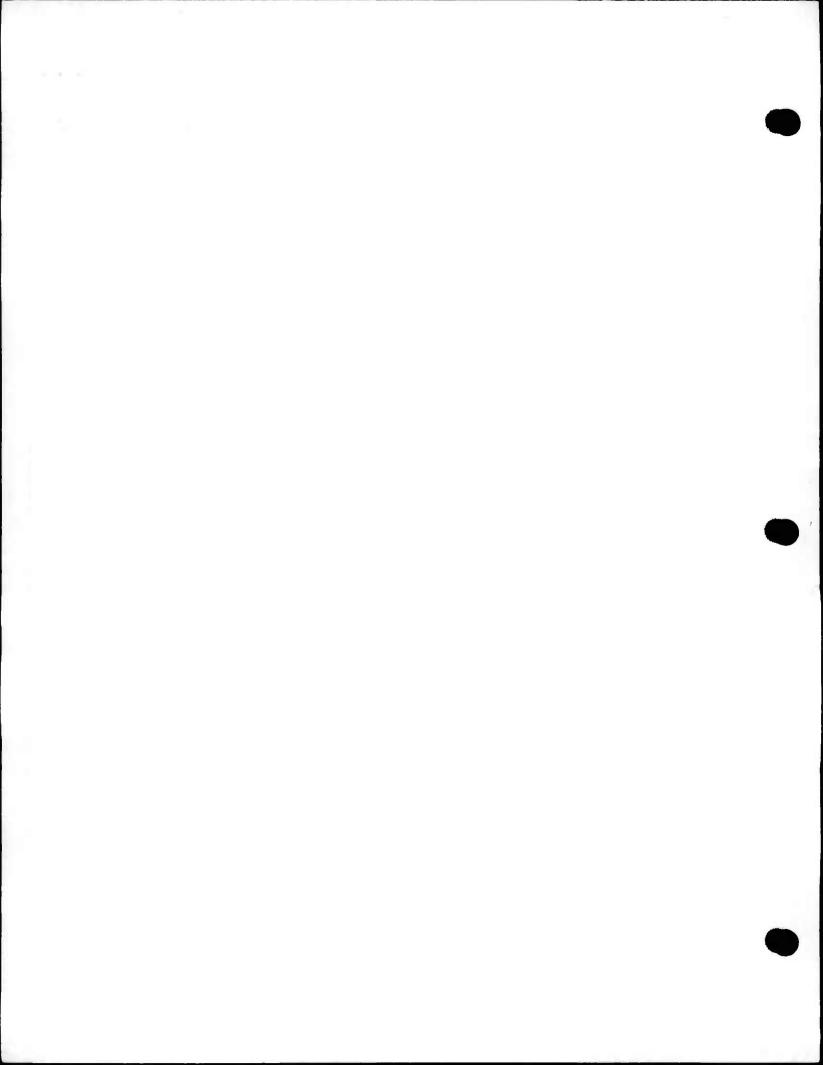
32 REGISTRAR'S SIGNATURE lia Triidson-Randalle

30. NAME AND AODRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-rours after death. Page 6 may be retained by the hospital or | TO THE FUNEAUS DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for | fter D | IMPORTANT: If Hem 28 of marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| Y AM | RECT | In a | m 2 |
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| H O | HT C | e file | MPO |
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| | 1 - FOR STATE OF M. | | | F HEALTH AND MOF DEATH | ENTAL HYGIENI REG. NO. | | 90 34138 | | |
|--------------------|--|--|------------------------------------|---|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) PORIS LUE LLA | - u | 11150 | \ A | 2. DATE OF DEATH DAY DAY DECEMber 1 | | 3. TIME OF DEATH | | |
| | 212-12-2659 1 D M 2 7 F | 6. AGE (In yrs. last birthday 70 YRS. | MONTHS D | AVR HOURS MIN | 7. DATE OF BIRTH (Month, Day, Year) Nov. 9, 1920 | C | Baltimore | | |
| OB | 96. FACILITY NAME (If not institution, give street end number) St. AGnes Hospital | | | IMOTE | тн | 9c. COUNTY (| OF DEATH | | |
| DIRECTOR | nesidence of decedent 10e. state 10b. county Maryland | | aty, town on a | | | 10d. INSIDE CITY LIMITS? 1 ▼ YES 2 □ NO | | | |
| FUNERAL | 100. STREET AND NUMBER 2011 Deering AVenue | | | 10f. ZIP CODE 21230 | | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| g | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA | EVER IN U.S. ARMED YES 2 NO IR OR DATES | if y | B DECENDENT OF HISPANI Ba, specify Cuben, Mexican, YES 2X NO Specify: | | | RACE — American Indian, Black, White, etc. Specify: WHite | | |
| COMPLETED | (Specify only highest grade completed) Elementery/Secondery (0-12) 9th Grade 15. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5 +) | 160. DECEDENT (Give kind of life. Do NOT House | of work done duri use retired.) | JPATION ng most of working | 16b. KIND OF BUS | INESS/INDUSTR | ay . | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) William O. Stone | | | | E (First, Middle, Melden S. Harku | | | | |
| 10 8 | 190. INFORMANT'S NAME (Type/Print) Thomas W. WIlson, SR. | 2011 | Deerin | treet and Number or Aural Ac g AVenue, B | Altimore, | Md. 21 | 230 | | |
| | 20e. METHOD OF DISPOSITION 120 Burlel 2 Cremetion 3 Removal from State 4 Oonation 5 Other (Specify) | New Cathe | ederal | | В | Altimo | | | |
| 77.5 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE WHITE CONTROL OF THE CO | 27 | Hub | me and address of fac bard Funera 17 WIlkens A | al Home In | | e, Md. 21229 | | |
| | 23. PART I. Enter the diseases, or complicatione that shock, or heart failure. List only one ceut IMMEDIATE CAUSE (Final disease or condition resulting in death) | ee on eech line. LUVO MA | + OF | e mode of dying, such | | | interval Between Onset and Desth | | |
| NO | DUE TO (OR AS A CONSEQUENCE OF): Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | reny, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury | f eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | |
| | resulting in deeth) LAST | | | | Part I. 24a, WAS AN | | | | |
| PHYSICIAN: MEDICAL | PART ii. Other significent conditions contributing to | seem but not resultin | g in the unde | mying cause given in i | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | OTHER: | 26. PLACE OF DEATH (Che | | | | | |
| BY PHYS | 27. MANNER OF DEATH Netural 5 Pending Investigation | ER/Outpatient 3 DOA INJURY ny, Year) 26b. 1 | | g Home 5 Reeldence lands. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW I | NJURY OCCURE | ED | | |
| | 3 Suicide 28e. PLACE OI | F INJURY — At home, ferretc. (Specify) | m, atreet, factor | r, office | 2af. LOCATION (Street and City or Town, State) | | lural Route Number, | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of one) 2 MEDICAL EXAMINER: On the best of examiners on the best of examiners. | | | | | | use(e) end manner es stated. | | |
| TO BE | 210 SIGNATURE AND TITLE OF CERTIFIER ST. AUNTS | AUSPITA | 4 | 29c. LICENSE NUM | BER | ≥ IA | IDAD | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OKETWING AYTHER 90 | O CATON | ype, Print) | BAITIMO | RE. MA | 212 | 29 | | |
| | DEC 12 1990 July Server | er-Aandese | | | | | , | | |



Pages 1, 2, 3 should

permit.

BE 9 29h, SIGNATURE AND TITLE OF CERTIFIER

31. DATE FILED (Month, Day, Year)

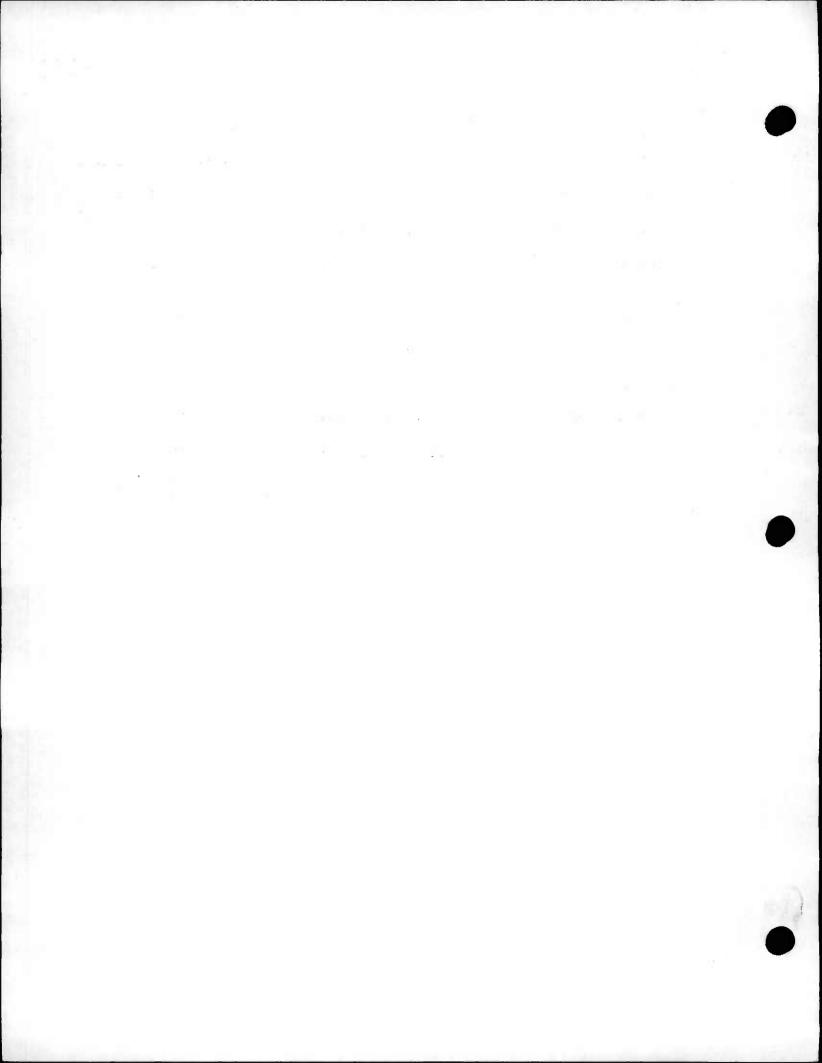
| THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Extributs after death. Page 6 may be retained by the hospital or attending physician | THE FLINERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transfer within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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90 34139 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) EDNA HELEN WALTROP 2 DATE OF OFATH 3. TIME OF DEATH MONTH 2 9 YEAR DNA 120 6. AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 76 11-17-14 213-01-0952 Maryland 1 M 2 X F YRS. 9a. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF OEATH DIRECTOR Baltimore Co. Gemeral Randallstown Baltimore RESIDENCE OF DECEDENT 10a. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Mary land Baltimore Pikesville 1 YES 2 NO 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20 Warren Park 21208 U.S.A. 12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indien, Black, White, etc. the procedure of the process of the 1 Never Married: 2 Married IF YES, GIVE WAR OR DATES BY 3 X Widowed 4 Divorced White COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs College (1-4 or 5+) Homemaker Own Home 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Lloyd W. Mitchell Isabelle Maher BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 Walter L. Waltrop 4106 Colby Rd. Baltimore, Md. 21208 20e, METHOD OF DISPOSITION
1 X Burlai 2 Cremation 3 Removal from Stata 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 4 Donation 5 Other (Specify) Parkwood 12-8-90 Parkville, Md. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc, 1050 York Rd. Towson, Md. 21204 23. PART I. Enter the disasses, or complications that caused tha death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximete shock, or haert failure. List only one cause on each line Interval Between IMMEDIATE CAUSE (Final LEUKEMIA Onset and Death disesse or condition resulting in death) CERTIFICATION Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY 285 TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural 5 Pending M 1 YES 2 NO BY investigation 2 Accident 3 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ETED 8 Could not be datarmined 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and menner as stated. COMPL 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

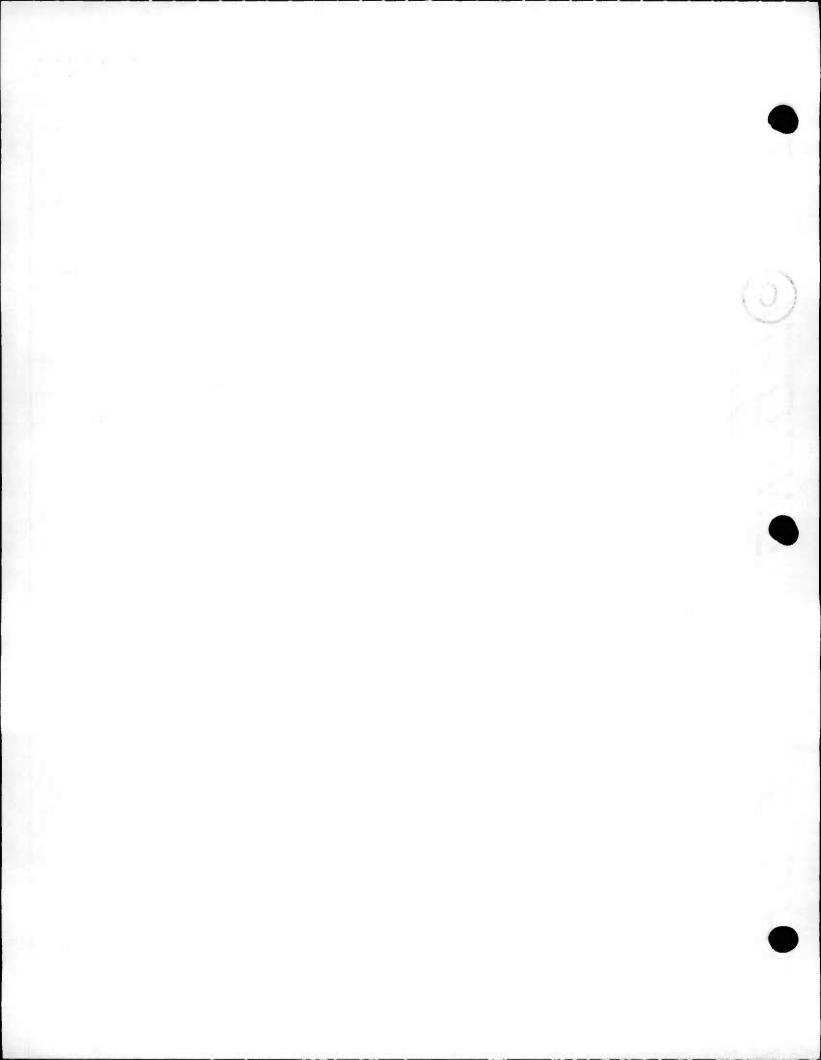
C-LAVI MD, BCGH, RAWD ALLSTOWN, MO 2 32. REGISTRAR'S SIGNATURE ulia Davidson



permit, Pages 1, 2, 3 should

| TO BE COMPLETE | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
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| al examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| wal. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| the funeral director, page 5 should be detached to use | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for users |
| ter death. Page 6 may be retained by the hospital or an | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within dury after death. Page 6 may be retained by the hamphill or may |
| BALTIMORE, MARYLAND 2120 | DIVISION OF VITAL RECORDS, P.O. BOX 13146, |

| | | CE | -AIII | CALE O | DEATH | | REG. NO. | | | |
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| DECEDENT'S NAME (First, Middle, Last) | _ | | | | | | DATE OF DEATH | Y | YEAR | 3. TIME OF DEATH |
| Elizabeth | | cock | | esenfe | | | 12/ 3/ | 199 | | 12 A |
| I. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | | | Month, Day, Year) | | 8. BIRTHI Country | PLACE (State or Foreign |
| 220 24 4231 | 1 🗆 M 2 🗔 F | 86 | YRS. | | | | 1/10/19 | | | yland |
| e. FACILITY NAME (If not institution, give s | treet and number) | | | 9b. CITY, TOWN | OR LOCATION | OF DEATH | | 9c. COU | NTY OF DE | EATH |
| 800 Southerly | Road | | | To | | Baltimore | | | | |
| ESIDENCE OF DECEDENT 9. STATE 10b. COUNTY 10c. CI | | | | V 70000 00 1 00 | ATIONI | | | | and liveres over | |
| | altimor | e Co | 10c. CITY, TOWN OR LOCATION TOWSON | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| Oa. STREET AND NUMBER | | | | | of. ZIP CODE | | | 10g. CITI | ZEN OF W | HAT COUNTRY? |
| EdenWald 800 S | outherl | v Rd | | | 2120 | 14 | | | USA | |
| 1. MARITAL STATUS Never Merried 2 Married Midowed 4 Divorced | 12. WAS DECEDEN | | MED NO | If yes, | | IISPANIC OF | RIGIN? (Specify Yea erto Rican, atc.) | fy Yea or No- 14. RACE - American | | |
| 15. DECEDENT'S EDU | CATION | 16a, DE | CEDENT'S | USUAL OCCUPA | TION | | 16b. KIND OF BUS | INESC/IND | HISTOV | White |
| (Specify only highest grade | completed) | (G | ive kind of v | vork done during : retired.) | nost of working | | .vv. cino or bus | | Joint | |
| Elementary/Secondary (0-12) | College 1-4 or 5 + | •) | | | | | A7 | 4 | | |
| CATHERIO MANACICE A MANACIO | yes | | | Retire | 7 | | Nurs | | | |
| 7. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER | T'S NAME (F | irst, Middle, Maiden | Surname) | | |
| H. GILMOR | POCOCK | | | | MAF | | ADDEN | | | |
| 9a. INFORMANT'S NAME (Type/Print) | | 198 | b. MAILING | ADORESS (Street | t and Number or | Rural Route | Number, City or Town | n, State, Zip | Code) | |
| Henry Wiesen | feld-Hu | sband | _800 | Sout | herly | Road | TOWSO. | n . M | ID 2 | 1204 |
| 23. PART I. Inter the diseases, or | | | | | | | | | | MD 21201 |
| immediate cause (Final disease or condition resulting in death) Sequentiely list conditions, if any, leeding to immediate | a. Meto DUE TO | t ceused the de | OUENCE OF | each | node of dying | , such aa | | ratory an | rest, | Approximete interval Between |
| immediate cause. (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. Met one country to be determined by the to determine to determine the total determined by the total | (OR AS A CONSECTION AS A CONSE | OUENCE OF | not enter the r | AM (P | , such aa | cardiec or respi | a i A |) | Interval Betwee |
| immediate cause. If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Met one country to be determined by the to determine to determine the total determined by the total | (OR AS A CONSECTION AS A CONSE | OUENCE OF | not enter the r | AM (P | , such aa | cardiec or respi | AUTOPSY MED? |) | Approximete interval Between |
| immediate cause. (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | a. Meta DUE TO b. DUE TO c. DUE TO d. HOSPITAL: | (OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CO | OUENCE OF | not enter the r | Ing ceuse give | en in Part | I. 24a. WAS AN PERFOR | AUTOPSY MED? |) | Approximate interval Batwo Onset and De 1/2 year Autopsy Findin Available Prior To Completion of Caus of Death? |
| MMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 1 Natural 5 Pending | a | (OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECT | OUENCE OF | P: 26. OTHER: 4 □ Nursing H | Ing ceuse give | en In Part TH (Check o | I. 24a. WAS AN PERFOR | AUTOPSY RMED? | 24b. | Approximate interval Batwo Onset and De 1/2 year Autopsy Findin Available Prior To Completion of Caus of Death? |
| immediate CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significent condition in the cause of the condition in the cause of | a. DUE TO b. DUE TO c. DUE TO d | (OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECT | OUENCE OF | P: 26. OTHER: 4 □ Nursing H EOF LIURY M 1 □ | Ing ceuse give | en in Part TH (Check o | I. 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY SMED? | 24b. | Approximate interval Batwo Onset and De 1/2 yes were autopsy findin available prior to completion of caus of Death? |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined | B. DUE TO | (OR AS A CONSECTION OF INJURY — At he atc. (Specify) | OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OF OUENCE OUENC | or enter the r | Ing ceuse glv | en In Part TH (Check o | I. 24s. WAS AN PERFOR 1 YES 2 Other (Specify) I. DESCRIBE HOW I City or Rown, State) | AUTOPSY RMED? | 24b. CURED r or Aural F | Approximate interval Betwo Onset and Da 1/2 year Autopsy Finon Awalable PRIOR TO COMPLETION OF CAUS OF DEATH? 1 YES 2 NO |



BALTIMORE, MARYLAND

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OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed HOSPITAL

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| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached we was attending physician and completely filled in by the funeral director, page 5 should be detached we was attended to the complete of the funeral director. | e flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

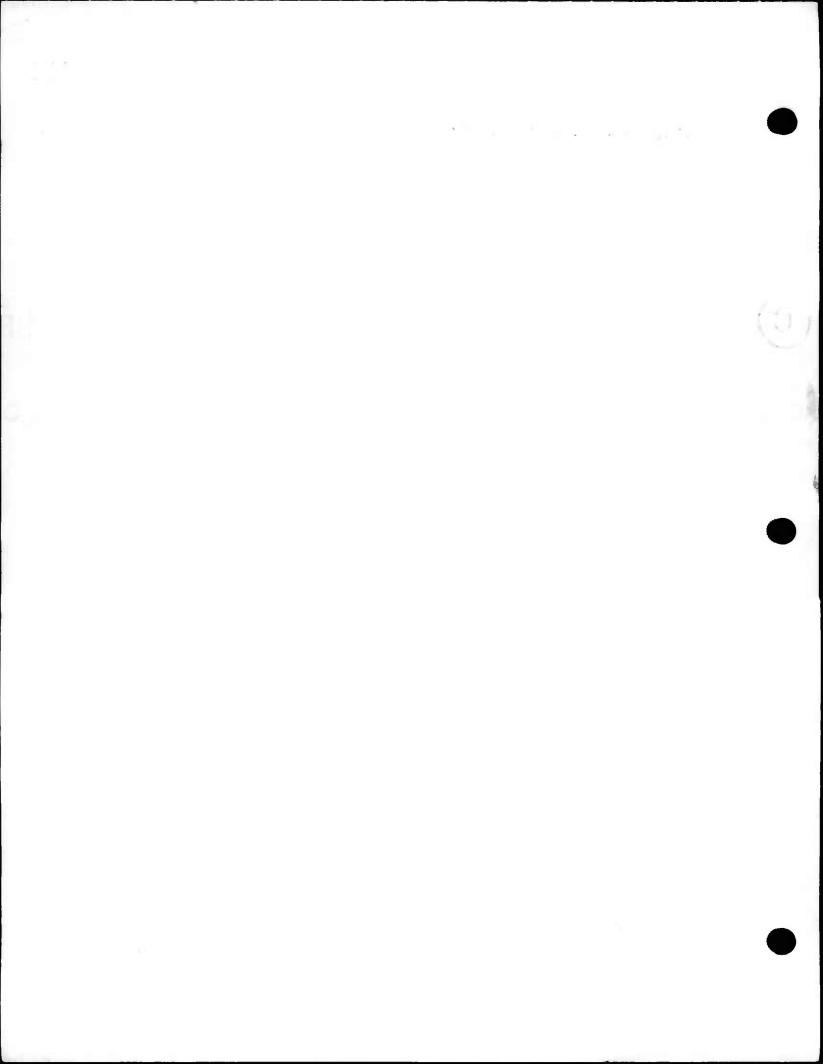
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P 3

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH WALKER DAY YEAR 0 HUDSON 0 5. SEX 8. AGE (In yrs. lest birthday) 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS BARN 222 22 0152 2-19-1937 Baltimore 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Western Maryland Center Washington Hagerstown, Maryland RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY LIMITS? 10a. STATE MD Washington Hagerstown 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? USA 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-FORCES? 1 YES 2-NO tf yes, specify Cuban, Mexican, Puerto Rican, etc.)

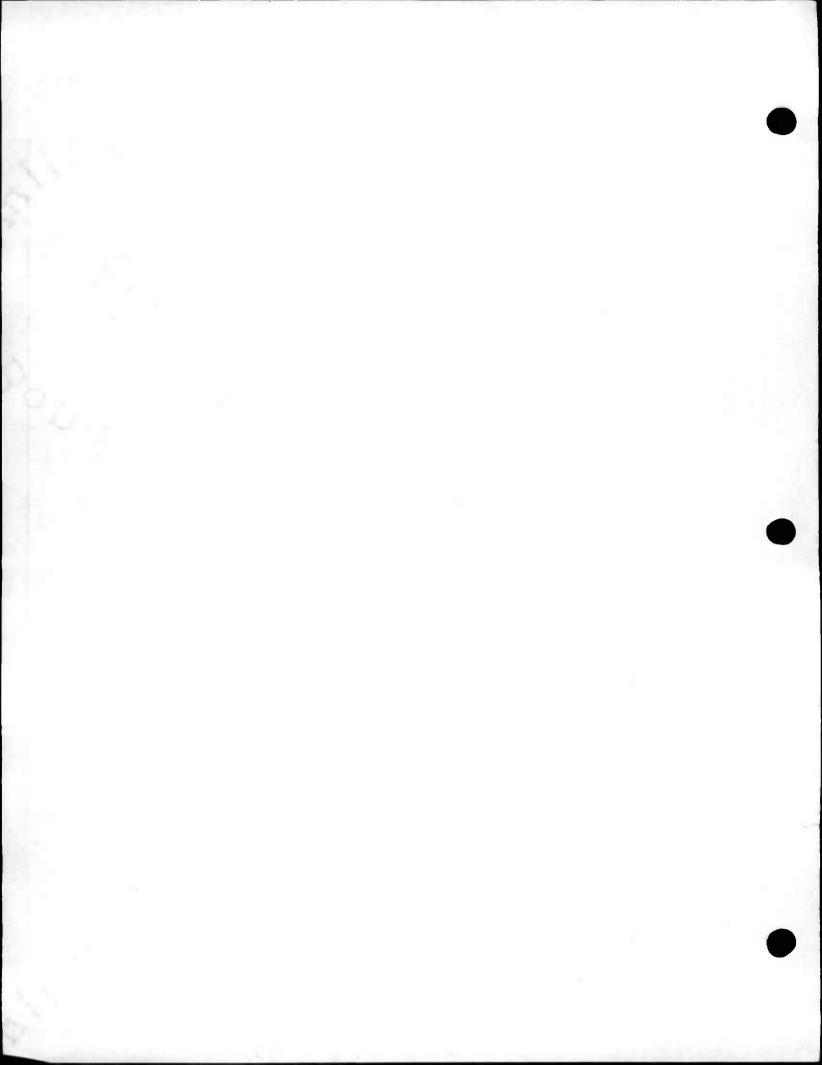
1 YES 2 NO Specify: 1 Never Married 2 Married Specify: BY 3 Widowed 4 Divorced White ETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Flementery/Secondary (0-12) College (1-4 or 5+) COMPL Laborer 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Majden Surname) BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 David Moore Soc Wk Western Md. Center, Hagerstown, MD 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, Stata 21. SIGNATURE OF FUNERAL SERVICE LICENSEE RONALD WADE, DIR 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD Kelle 655 W. Balto.St, Balto, MD 21201 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such sa cardisc or respiratory arrest, Approximete ehock, or heert fellure. Liet only one cause on each line. interval Between Onaet end Death IMMEDIATE CAUSE (Finsi 1 disesse or condition resulting in death) Carcinoma monta CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST 6 PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? WAILABLE PRIOR TO and COMPLETION OF CAUSE 1 | YES 2 | NO 1 YES 2 NO PHYSICIAN: S 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 5 27. MANNEY OF DEATH 28c. INJURY AT WORK? 28s. DATE OF INJURY 28b. TIME OF 28d. DEŞCRIBE HOW INJURY OCCURED marked, 1 Natural 5 Pending М 1 YES 2 NO BY 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide ** 8 Could not be ED 4 Homicida 82 COMPLET Hem 20a CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the ceuse(e) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(e) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year)

29c. LICENSE NUMBER



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 12 wours after death. Page 6 may be retained by the h | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page for the size of the death, with the State Deat of Health and Mental Harilene unit to build, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be negliged at the |
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| _ | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAND C | DEPAR | | | | | MENTAL | HYGIEN | | 90 | 34142 |
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| | 1. DECEDENT'S NAME (First. | Middle, Last) | | | | | - | | | 2. DATE C | F DEATH | | | 3. TIME OF DEATH |
| | ELMER | | ATWOOD | 1 | WALLA | CE | | | | MONTH 12 | DA | | EAR () | 04:50A M |
| | 4. SOCIAL SECURITY NUMB | | 5. SEX | 6. AGE (In yrs. la | | IF UNDER | 1 YEAR | IF UNDER | R 24 HRS. | 7. DATE C | | | | PLACE (State or Foreign |
| | 212-03-403 | 3 | 1 XM 2 - F | 80 | | MONTHS | DAYS | HOURA | MIN. | (Month, Day, Year) Co. | | Country |) | |
| œ | 98. FACILITY NAME (If not institution, give street and number) 98. CITY, TOWN OR LOCATION OF DE GREATER BALTIMORE MEDICAL CENTER TOWSON | | | | | | | | | | | | | |
| 5 | RESIDENCE OF DEC | | KE MEDIC | AL CENT | LK | | | COWSC | JN | | | BAL | TIM | ORE |
| DIRECTOR | 10a. STATE MARYLAND | 10b. COUNTY | ALTIMORE | | 10c. CITY, TOWN OR LOCATION BALTIMORE | | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
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| 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | | RMED 13. WAS DECENOENT OF HISPAN | | | | | | | or No.— 1 | | - American Indian, White, atc. |
| BYF | 1 Never Married 2 2 | | | YES 2 MAR OR DATES | NO If yes, specify Cuban, Mexica 1 TES 2 NO Specify | | | | and a manual area | | | Specify | y: | |
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| COMPLETED | Elamentary/Secondary (0- | -12) | College (1-4 or 5 | +) " | | | | | | 3 . | | | | |
| \$ | 17. FATHER'S NAME (First, Mi | della I nett | | | Pnc | tog | rap. | Y | THED'S NA | ME /First A/ | iddie, Maiden | Sumamal | | |
| BEC | FREDERIC | | LLACE | | | | | | MMA | | AUF | Surramay | | |
| 0 | 19a. INFORMANT'S NAME (7) | rpe/Print) | | | | | | | | | | n, State, Zip C | | 21030 |
| 7 | Ruth Wal | | (wife | | | | | | | t Wa | | | | le,MD |
| | 20a. METHOD OF DISPOSITI | n 3 🗆 Rem | oval from State | 20b. PLACI | | SITION (N | ame of ce | metery, cre | matory or | | 20c. LOCATION — City or Town, State | | | |
| | 4. Donation 5 Other | | CENSEE | | | 22 | NAME A | NO ADDR | ESS OF FA | CILITY | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE ROnald Wade, Dir 22. NAME AND ADDRESS OF FACILITY STATE ANATOMY BOARD | | | | | | | | | | | | | |
| | Sundy/////// 655 W.Balto St, Balto., MD 21201 | | | | | | | | | | | | | |
| | 23. PART I. Enter the di | | | | | not snta | r tha mo | oda of dy | ying, suc | h aa card | lac or reep | iretory arre | st, | Approximata interval Between |
| | shock, or haert feliure. List only one cause on each line. IMMEDIATE CAUSE (Final | | | | | | | , | Onset and Death | | | | | |
| 1 | disease or condition resulting in death) | → | 8 | | DIORESPIRATORY ONSET 4 | | | | | 91 | rest | | | Ihs. |
| ŀ | DUE TO (OR AS A CONSEQUENCE OF): ISCHEMIC CARDIOMYOPATHY 24 Ms. | | | | | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, DUF TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | | | | |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | | | | |
| Ē | CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| E | resulting in death) LAS | T | d | | | | | | | | | | | |
| | PART II. Other algolitica | nt condition | ns contributing to | death but not | regulting | In the u | nderlyin | o called | alven in | Dart I | 24s. WAS AN | AUTODEV | 24h | WERE AUTOPSY FINDINGS |
| CAL | PART III. Outer algument | THE CONTRACTOR | - Continuating to | J Guida Dat Hot | resulting | | - Carry | y cause | given in | 7 417 1. | PERFO | RMED? | 240. | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | | | | | | | | | | - 1 | 1 TYES | NO | | OF DEATH? |
| Σ | | | | | | | | | | | | | | 1 TES 2 NO |
| AN | 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26.5 | H ACE OF | DEATH /C | baak aak aa | -1 | | Щ. | |
| <u> </u> | EXAMINER? | OWEDICAL | HOSPITAL: | | | OTHE | R: | | | heck only on | • | | | |
| (n) | TO TES 2 VIO | YES 2 NO Propertient 2 ER/Outpetlant 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | IN ILIBA OCCI | IBEN | |
| ≥ | 27 MANNER OF OFATH | 1 Netural 5 Pending (Month, Day, Year) INJURY WORK? | | | | | | | | | | | | |
| PHYSICIAN: MEDIC | | | (Month, | 24, 104, | | 2 Accident Investigation 28s. PLACE OF INJURY — At home, farm, street, factory office 28s. LOCATION (Street and Number or Bural Boute Number | | | | | | | | |
| BY | 1 Natural 5 2 Accident | Investigation | 28a. PLACE | OF INJURY — At | home, ferm | , street, fac | | | | | | | r Rural F | Route Number, |
| ED BY | 1 Natural 5 2 Accident 3 Suicide 6 | | 28a. PLACE | | home, ferm | , street, fac | | | | | ATION (Street or Town, State | | r Rural F | Route Number, |
| ED BY | 1 Natural 5 | Investigation Could not be determined | 28a. PLACE building | OF INJURY — At a | | | ctory, offi | ce | | City | or Town, State |) | | loute Number, |
| ED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only 1) | Could not be determined | 28a. PLACE building | OF INJURY — At I | death occu | rred at the | ctory, offi | ce a and place | ce, and du | City | or Town, State | nner as state | d. | noute Number, |
| COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only 1) | Could not be determined | 28a. PLACE building SICIAN: To the best of ER: On the basis of | OF INJURY — At I | death occu | rred at the | ctory, offi | a and plac | ce, and du | City a to the cau | or Town, State | nner as state | d. cause(a | |
| BE COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29s. CERTIFIER (Check only only) 2 MED | Could not be determined | 28a. PLACE building SICIAN: To the best of ER: On the basis of | OF INJURY — At I | death occu | rred at the | ctory, offi | a and plac | ce, and du | City a to the cau | or Town, State | nner as state | d. cause(a | end manner as attated. |
| COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29s. CERTIFIER (Check only only) 2 MED | Investigation Could not be determined TIFYING PHYS IICAL EXAMINI | 28s. PLACE building | OF INJURY — At I | death occur or investigat | rred at the | ctory, offi | a and plac | ce, and du | City a to the cau | or Town, State | nner as state | d. cause(a |) and manner as stated. (Month /Day, Year) |
| BE COMPLETED BY | 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only 1 Only) 2 MED 29b. SISNATURE AND TITLS | Investigation Could not be determined TIFYING PHYS IICAL EXAMINI | 28a. PLACE building | OF INJURY — At I | death occur or investigat | rred at the | time, dat | a and plac | ce, and du | City a to the cau | or Town, State | nner as state | d. cause(a |) and manner as stated. (Month /Day, Year) |



1990

3. TIME OF DEATH

1:55

2. DATE OF OBATH DAY
December 10.

FOR STATE REGISTRAR

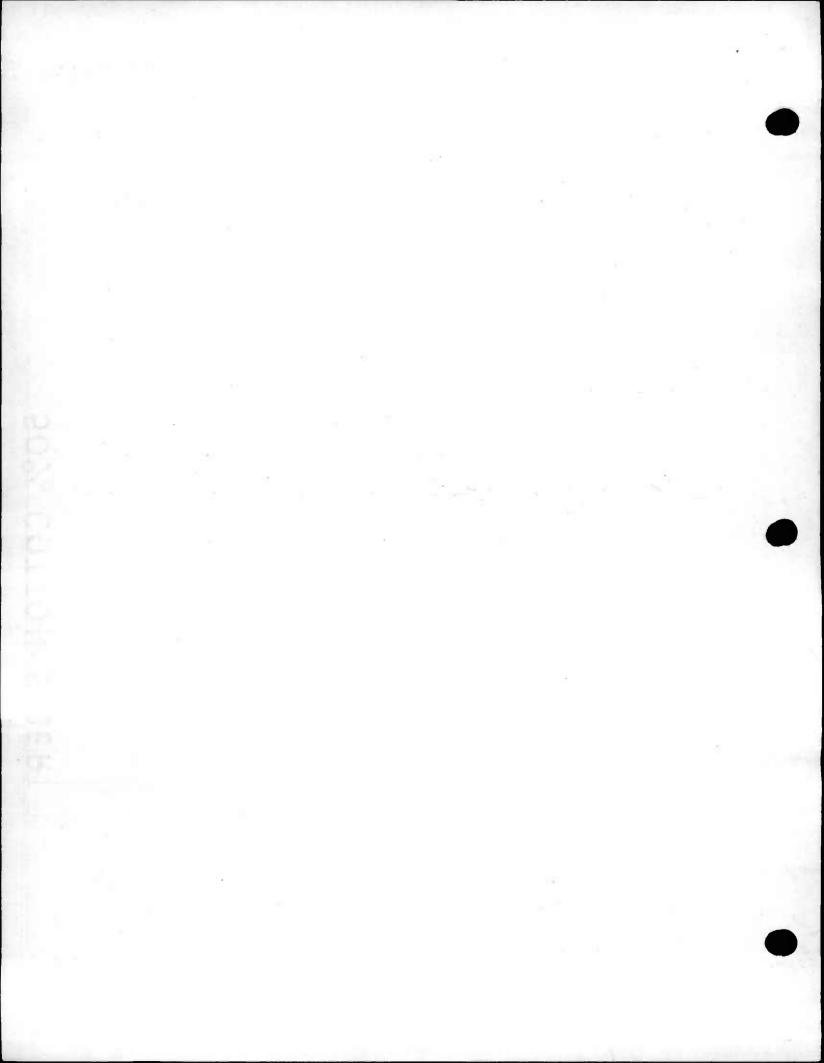
George

1. DECEDENT'S NAME (First, Middle, Last)

YOUNG

| of working B. MOTHER'S NAME Christin. Number or Rural Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller elair Rd | ORIGIN7 (Specify Year or Puerto Rican, atc.) 18b. KIND OF BUSINE Nabisco (First, Middle, Maiden Sur a Steinbac te Number, City or Yown, S to., Md. 2 20c. LOCAT Balt | Og. CITIZEN OF WHAT USA NO— 14. RACE — A Black, Wh Specify: ESS/INDUSTRY TREMO 1206 TION — City or Town, S O., Md. Md. 21206 | INSIDE CITY LIMITS? YES 2 1 P COUNTRY? American India Hite, etc. White | | | | | |
|--|--|---|--|--|--|--|--|--|
| DENT OF HISPANIC ty Cuban, Mexican, F X NO Specify: of working 18. MOTHER'S NAME Christin Number or Rural Rou Ave. Bal ary, cremetory or ADORESS OF FACIL Elair Rd | Of ORIGIN7 (Specify Yea or Puerto Rican, atc.) 18b. KIND OF BUSINE Nabisco (First, Middle, Maiden Sur a Steinbac to Number, City or Town, S to., Md. 2 20c. LOCAT Balt ITY Inc. Balto., | Og. CITIZEN OF WHAT USA NO— 14. RACE — A Black, Wh Specify: ESS/INDUSTRY TREMO 1206 TION — City or Town, S O., Md. Md. 21206 | LIMITS? YES 2 COUNTRY? American India its, etc. White Approximatinterval Be | | | | | |
| DENT OF HISPANIC Ty Cuben, Mexican, F X NO Specify: of working 18. MOTHER'S NAME Christin Number or Rural Rou Ave. Bal ary, cremetory or ADORESS OF FACIL Miller elair Rd | Of ORIGIN7 (Specify Yea or Puerto Rican, atc.) 18b. KIND OF BUSINE Nabisco (First, Middle, Maiden Sur a Steinbac to Number, City or Town, S to., Md. 2 20c. LOCAT Balt ITY Inc. Balto., | Og. CITIZEN OF WNAT USA No 14. RACE — A Black, Wh Specify: Theme) h State, Zip Code) 1206 TION — City or Town, S O., Md. Md. 21206 | OUNTRY? American India ite, etc. White Approximation interval Be | | | | | |
| DENT OF HISPANIC Ty Cuben, Mexican, F X NO Specify: of working 18. MOTHER'S NAME Christin Number or Rural Rou Ave. Bal ary, cremetory or ADORESS OF FACIL Miller elair Rd | Of ORIGIN7 (Specify Yea or Puerto Rican, atc.) 18b. KIND OF BUSINE Nabisco (First, Middle, Maiden Sur a Steinbac to Number, City or Town, S to., Md. 2 20c. LOCAT Balt ITY Inc. Balto., | USA No- 14. RACE — A Black, Wh Specify: Parme) h State, Zip Code) 1206 FION — City or Town, S O., Md. Md. 21206 | Approxima | | | | | |
| DENT OF HISPANIC ty Cuben, Mexican, F. X NO Specify: of working 18. MOTHER'S NAME Christin. Number or Rural Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller celair Rd | ORIGIN7 (Specify Yea or Puerto Rican, atc.) 18b. KIND OF BUSINE Nabisco (First, Middle, Maiden Sur a Steinbac to Number, City or Town, S to., Md. 2 20c. LOCAT Balt TY Inc. Balto., | No.— 14. RACE — A Black, Wh Specify: ESS/INDUSTRY Therme) h State, Zip Code) 1206 TION — City or Town, So., Md. Md. 21206 | Approximatinterval Be | | | | | |
| of working B. MOTHER'S NAME Christin. Number or Rural Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller elair Rd | Nabisco (First, Middle, Maiden Sur a Steinbac te Number, City or Town, S to., Md. 2 20c. LOCAT Balt TY Inc. Balto., | Black, Wh Specify: ESS/INDUSTRY Therme) h State, Zip Code) 1206 TION — City or Town, S O., Md. Md. 21206 | Approximating of the state of t | | | | | |
| Christin. Number or Rural Rou Ave. Bal ary, cremetory or ADORESS OF FACIL Elair Rd | Nabisco (First, Middle, Meiden Sur a Steinbac te Number, City or Town, S to., Md. 2 20c. LOCAT Balt TY Inc. Balto., | h h State, Zip Code) 1206 TION — City or Town, S O., Md. | Approxima | | | | | |
| Christin. Number or Rurel Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller elair Rd | (First, Middle, Meiden Sur a Steinbac te Nurmber, City or Town, S to., Md. 2 20c. LOCAT Balt | h State, Zip Code) 1206 TION — City or Town, S O., Md. Md. 21206 | Approxima | | | | | |
| Christin. Number or Rurel Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller elair Rd | (First, Middle, Meiden Sur a Steinbac te Nurmber, City or Town, S to., Md. 2 20c. LOCAT Balt | h State, Zip Code) 1206 TION — City or Town, S O., Md. Md. 21206 | Approxima | | | | | |
| Christin. Number or Rurel Rou Ave. Bal ery, cremetory or ADORESS OF FACIL Miller elair Rd | a Steinbac to Number City or Town, S to ., Md. 2 20c. LOCAT Balt Try Inc. Balto., | h State, Zip Code) 1206 TION — City or Town, S O., Md. Md. 21206 | Approxima | | | | | |
| Ave. Bal ave, cremetory or ADORESS OF FACIL Miller elair Rd | to., Md. 2 to., Md. 2 20c. LOCAT Balt TY Inc. Balto., | 1206 100 - City or Town, S 0., Md. | Approxima | | | | | |
| Ave. Bal ary, cremetory or ADORESS OF FACIL Miller elair Rd | Balt Inc. Balto., | 1206 TION - City or Town, S O., Md. Md. 21206 | Approxima | | | | | |
| ADORESS OF FACIL Miller elair Rd | Balto., | 710N — City or Town, \$ 0., Md. Md. 21206 | Approxima | | | | | |
| ADORESS OF FACIL . Miller elair Rd | Inc. Balto., | Md. 21206 | Approxima Interval Be | | | | | |
| . Miller elair Rd | Inc. Balto., | Md. 21206 | Approxima Interval Be | | | | | |
| elair Rd | . Balto., | | Approxima | | | | | |
| | | | Approximation | | | | | |
| or dying, auch e | e cerdiec or respirat | ory arreet, | Interval Bo | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in deeth) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | |
| PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY 24b, WERE AUTOPSY FINDI | | | | | | | | |
| Congestive Hearth Failure | | | | | | | | |
| Congestive Hearth Failure 1 □ YES 2 X NO 1 □ YES 2 X NO | | | | | | | | |
| CE OF DEATN (Check | only one) | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATN (Check only one) THOSPITAL: 1 YES 2 NO 27. MANNER OF OEATN 28. DATE OF INJURY (Month, Day, Vear) 28. INJURY AT WORK? | | | | | | | | |
| (7 | ad, DESCRIBE NOW INJU | JRY OCCURED | | | | | | |
| 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation 28- PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Burel Roo. | | | | | | | | |
| 2 | 81. LOCATION (Street and City or Town, State) | Number or Rural Route | Number, | | | | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | | | | |
| 237 8 | ER FIZ | 9d. DATE SIGNEO (Mor | nth, Day, Year) | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | |
| Sq. Dr., | Barto. | | | | | | | |
| | 5 Residence 6 TY AT 2 TY AT 2 S 2 NO 2 not place, and due to the occured at the times are considered at the times | 28d. DESCRIBE NOW INJECT OF TOWN, Strate) 28f. LOCATION (Street and City or Town, Strate) 28f. LOCATION (Street and City or Town, Strate) 28f. LOCATION (Street and city or Town, Strate) 28f. LOCATION (Street and City or Town, Strate) | 5 Residence 6 Other (Specify) 77 AT 28d. DESCRIBE NOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route City or Town, State) 281. LOCATION (Street and Number or Rural Route City or Town, State) 281. LOCATION (Street and Number or Rural Route City or Town, State) 281. LOCATION (Street and Number or Rural Route City or Town, State) 281. LOCATION (Street and Number or Rural Route City or Town, State) 282. LICENSE NUMBER 293. DATE SIGNEO (Mo | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



permit. Pages 1, 2, 3 should

9

Dr.

Constante

31. DATE FILED (Month, Day, Year)
DEC 13 1990

| | FOR 1 - STATE | STATE OF MARYLAND / | | | | | | UJ | ls I ls ls | | |
|--|--|---|-------------------|---------------------------------|--|---|---------------------|----------------------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | Cl | RITE | CATE O | F DEATH | 2. DATE OF DEATH | | 3. TIM | E OF DEATH | | |
| | | dkins | | | | December | 9. 199 | 0 | 4:20pm | | |
| | 222 16 1566 | 5. SEX 8. AGE (In yrs. les 5 9 | | MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) March 12 | 3 | BIRTHPLACE Country) Maryla | (State or Foreign | | |
| | 9a. FACILITY NAME (If not institution, give stre | eet and number) | | 9b. CITY, TOW | N OR LOCATION OF DI | | 9c. COUNTY OF DEATH | | | | |
| CTOR | Deer's Head Center | <u>r</u> | | Salis | bury | | Wicomico | | | | |
| DIRECTOR | Maryland Worce | ster | Ber | town or lo | CATION | | | , Ji | ISIDE CITY MITS? YES 2 NO | | |
| FUNERAL | 10a. STREET AND NUMBER 111 West Street | | | | 101. ZIP CODE 21811 | | - | OF WHAT CO | OUNTRY? | | |
| ₹ | | 12. WAS DECEDENT EVER IN U.S. AR | MED | 13. WAS E | ECENDENT OF HISPAI | NIC ORIGIN? (Specity Ye | | RACE - Ami | rican Indian, | | |
| m m | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 Tyes 2 Tyes IF YES, GIVE WAR OR DATES | 10 | | specify Cuban, Maxico ES 2 (NO Specif | | | Black, White Specify: W | hite | | |
| COMPLETED | 15. DECEDENT'S EOUCA (Specify only highest grade of | ompleted) (G | ive kind of w | JSUAL OCCUPI ork done during | TION most of working | 16b. KIND OF BU | ISINESS/INDUST | TRY | | | |
| ١٣ | Elamantery/Secondary (0-12) | College (1-4 or 5+) | Do NOT use | | | | | | | | |
| ğ | 12 17. FATHER'S NAME (First, Middle, Last) | Ho | usew | ife | | | | | | | |
| | Edgar Wells, Sr. | | | | | AME (First, Middle, Malder | Sumame) | D1 : 111 | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 19 | MAILING | ADDRESS (Street | Elizab | Route Number, City or Tox | un State 7in Cou | Philli | ps | | |
| 임 | Raymond C. Adki | I | | | . Berlin | • | 1811 | 36) | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Remove 4 Donation 5 Other (Specify) | val trom State 20b. PLACE other pl | of Disposi | vergre | en Ceme | | erlin, | or Town, Sta | 18 | | |
| | 22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home Berlin, MD | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or co | omplications that caused the de | ath. Do n | ot enter the | mode of dying, suc | ch ee cardlec or reep | iratory errest | . 17 | pproximete | | |
| | shock, or heert fallure. Li iMMEDIATE CAUSE (Final | ist only ohe cause on each line | | | | | | 1 6 | ntervel Between Onset end Deeth | | |
| | diseese or condition | Carcinoma of | the S | tomach | with liv | er Metatas | is | į. | | | |
| | a. Cal Ciliona of the Stonach With Liver Metatasis Due to (or as a consequence of): | | | | | | | | | | |
| 2 | Sequentially liet conditions, Congestive Heart Failure | | | | | | | | | | |
| CERTIFICATION | If eny, leeding to Immediate | | | | | | | | | | |
| 2 | CAUSE (Dieeese or injury | DUE TO (OR 10 1 00107 | | | | | | | | | |
| Ë | that initiated events regulting in death) LAST | DUE TO (OR AS A CONSE | AUENCE OF |): | | | | i | | | |
| 崽 | d. | | | | | | | | | | |
| ا بـ | PART ii. Other eignificant conditions | | | - | - | | | | AUTOPSY FINDINGS | | |
| 5 | Carcinoma of the breast, right Mastectomy | | | | | | | | BLE PRIOR TO ETION OF CAUSE ATH? | | |
| MEI | | | | | | | | | ES 2 NO | | |
| ä | | | | | | | | | | | |
| SIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | ҢOSPITAL: | | | PLACE OF DEATH (C) | heck only one) | | | | | |
| Š | 1 TYES 2 NO | 1 Inpatient 2 ER/Outpatient 3 | □ DOA | OTHER: 4 Nursing H | lome 5 🗆 Realdanca | 6 Other (Specify) | | | | | |
| PHYSICIAN: MEDICA | 27. MANNER OF DEATH 14 Natural 5 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | JRY | INJURY AT WORK? | 28d. DEŞCRIBE HOW | INJURY OCCUR | ED | | | |
| B√ | 2 Accident Investigation | | | | YES 2 NO | | | | | | |
| TED | 3 Suicide 8 Could not be 4 Homicida datarmined | 28e. PLACE OF INJURY — At he building, atc. (Specify) | me, term, s | treat, factory, o | ffica | 28t. LOCATION (Street City or Town, Stets | | Rural Route Nu | mber, | | |
| COMPLETED | ona) — | IAN: To the best of my knowledge, de | | | | | | | | | |
| 8 | 2 MEDICAL EXAMINER | On the basis of examination and/or | investigation | i, in my opinio | | | nd due to the c | ause(a) end m | enner as stated. | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month MD 16725) 29d. DATE SIGNED (MONTH MD 16725) 29d | | | | | | | | GNED (Month | 90 | | |

Salisbury,

21802

45

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Fan, P.O. Box 2018, Salis

32. REGISTRAR'S SIGNATURE

Tan,

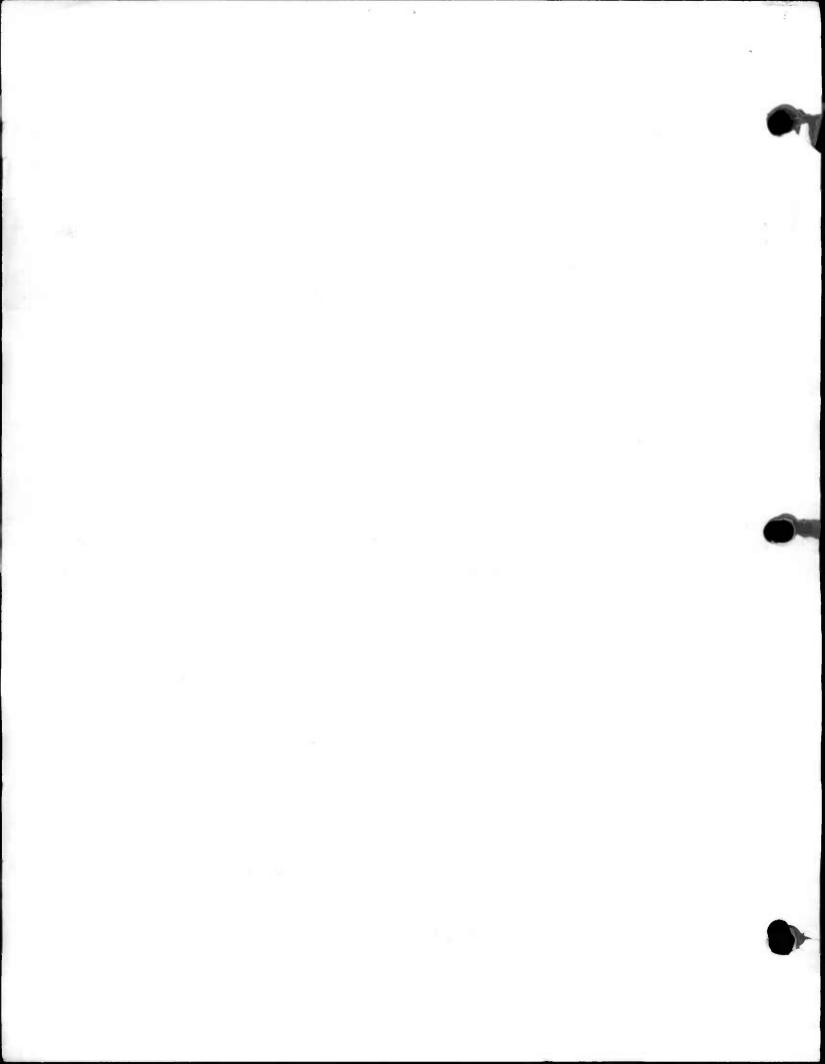
1

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the part of the float. Place 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|---|
|---|

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | ,,,,,, | CERTIFIC | CATE O | F DEATH | RE | G. NO. | • | | | |
|---------------------|--|---|----------------------|-----------------|---|--|----------------------|--------------|-------------------|--|---------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF D | | . 1 | 02020 | 3. TIME OF DEATH | 6 |
| | JAOS W. | ANDERS | 00 | | | MONTH . | T DA | 190 | YEAR | 2:45 | м |
| | 4. SOCIAL SECURITY NUMBER 5. | | | IF UNDER 1 YEAR | R IF UNDER 24 HRS. | 7. DATE OF BI | RTH 3 | • • | | PLACE (State or Foreign | n - |
| | יו עונה המי המים | M 2 DEF BL | | MONTHS DAY | HOURS MIN. | (Month, Day | | 001 | Countr | | |
| | 9a. FACILITY NAME (if not institution, give street | 0 | | on CITY TOW | N OR LOCATION OF DE | | 13 | PO COLI | NTY OF D | JURATA TA | 0.0 |
| - | 1 | | | 30. CITT, 10W | N ON LOCATION OF DE | AIN | _ ' | 0 | | • | |
| 5 | 412 FOX CHA | PEL DRII | 12 | lin | MUIDOL | | | D | ALT | imore | |
| ו וּ | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CITY. | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY | |
| | Maryland Bar | - 01 | - | | | | | | | LIMITS? | |
| 3 | 100, STREET AND NUMBER | TIMORE | 111 | WOL | 101, ZIP CODE | | _ | 40 00 | | VHAT COUNTRY? | - |
| \$ | 1 | an Das | | | 101. ZIP CODE | _ | | 10g. CI1 | IZEN OF V | VHAI COUNTRY? | - 1 |
| | 412 FOX CHA | PEL URI | 13 | | 2109 | <u> 3 </u> | | | 1-2 | ·H- | |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS 12 1 Never Married 2 Married | . WAS DECEDENT EVER IN U FORCES? 1 YES | J.S. ARMED 2 XNO | 13. WAS E | ECENDENT OF HISPAI specify Cuban, Maxica | NIC ORIGIN? (Sp in, Puarto Rican | ecify Yaa , atc.} | or No- | 14. RACE Black | — American Indian, c, White, atc. | |
| = | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | ES | | ES 2 NO Specif | | | | Speci | N: 1- | - 1 |
| - 1 | | T | | 1 | | | | | W | 4114 | - |
| <u> </u> | 15. DECEDENT'S EDUCATI (Specify only highest grade com | on ipleted) | (Give kind of wo | ork done during | most of working | 166. KINI | OF BUS | INESS/IN | DUSTRY | | 1 |
| ا ك | Elementary/Secondary (0-12) | college (1-4 or 5+) | ille. Do NOT use | | | | | | | | 1 |
| COMPLETED | 1216 | 4 YRS. | 1- | H_{ν} | 370 | | | | | <u> </u> | |
| 3 | 17. FATNER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle | , Malden : | Surname) | | | |
| | HTNU 7- | WHITT | 157 | | 272 | 18 2. | . 7 | Wi | ART | TUOUT | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Stre | et and Number or Rural | Route Number, C | ity or Town | , State, Zi | ip Code) | | |
| ا - | FAMILY KEE | OR.OS | 2 | AMS | As F | Boys | | | | | |
| - 1 | 20a. METHOD OF DISPOSITION | 20b. i | PLACE OF DISPOSI | TION (Name of | cemetery, cremetory or | | | CATION - | City or To | own, State | |
| -1 | 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | Trom State | other place) | David | TTESME | MORY | \mathcal{B} | TLA | 5. 6 | 70. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | | 1111111111 | | AND ADDRESS OF FA | CILITY | 2 6 | 11:0 | 17.0 | | \neg |
| | • ((2)) | _ | | 24 | ghz, ena | INST O | 4 | 2011 | الك | | - 1 |
| _ | | Norma, Ar | | 3.3 | 35 YORS | 160AC |) - 1 | in | 1001 | mu | _ |
| | 23. PART I. Enter the diseases, or com shock, or heart fellure. List | plications that caused t | tha death. Do no | ot antar tha | moda of dying, aud | ch aa cerdlec | or respi | ratory a | rrest, | Approximate interval Batwe | |
| | IMMEDIATE CAUSE (Fine) | ^ 1 | | | | | | | | Onset end Da | |
| | disease or condition | Color | 1 Can | er. | | | | | | 1 54M | 2 |
| - 1 | reaulting in death) e | DUE TO (OR AS A | CONSEQUENCE OF |): [| | | | | | - | |
| _ | - Metastoses to Liver 245 | | | | | | | | | | |
| 5 | Sequentially list conditions, If eny, laading to immediata DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | ceuse. Enter UNDERLYING | | | | | | | | | | |
| Ĭ | CAUSE (Diseesa or injury that initiated avents | DUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | |
| = | resulting in death) LAST | | | | | | | | | | - 1 |
| 5 | | | | | | | | | | | |
| S S | PART II. Other significant conditions of | ontributing to death bu | t not reculting in | n the underl | ying ceuea givan in | Part i. 24a | PERFOR | | 24t | WERE AUTOPSY FINDII AVAILABLE PRIOR TO | INGS |
| 2 | | | | | | 10 | YES 2 | NO | - 1 | COMPLETION OF CAUS OF DEATN? | SE |
| | | | | | | | | | | 1 YES 2 NO | |
| - | | | | | | | | | | | |
| CIAN: ME | 25. WAS CASE REFERRED TO MEDICAL | | | 20 | . PLACE OF DEATN (C) | heck only one) | | | | | - |
| | | IOSPITAL: | tlant 3 DOA | OTHER: | Name ed Davidson | e 🗆 Other (Co | anth i | | | | |
| PHYSI | 27. MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | | Nome 5 Residence | 26d. DESCRI | | N.IIIRY O | CCURED | | |
| | 1 Naturat 5 Pending | (Month, Day, Year) | INJ | JRY | WORK? | 200, 02001 | DE 11011 | | 0001122 | | - 1 |
| BY | 2 Accident Investigation | 26a. PLACE OF INJURY - | At home form | | | 200 1 0001710 | M (Da | - m ad Adv b | | Route Number, | \rightarrow |
| | 3 Suicide 6 Could not be 4 Nomicide determined | building, atc. (Specif | | traet, mictory, | omea | | wn, State) | | er or Hurai | Houte Number, | - 4 |
| | | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only | N: To the best of my knowle | dge, death occurre | d at the time, | deta and place, and du | a to the cause(s |) and mai | nner aa si | sted. | | |
| S I | one) 2 MEDICAL EXAMINER: | On the beals of exemination | and/or investigation | n, in my opinic | n, death occured at the | a time, data and | placa, an | nd due to | the cause(| a) and menner as state | ed. |
| | 296. SIGNATURE AND TITLE OF RERTIGIER . | 0 0 | | | 29c. LICENSE NU | IMBER | | 29d. DA | TE SIGNE | D (Month, Day, Year) | \dashv |
| BE | reallutioner | anum | | | 0324 | 1-00 | | 14 | 150 | 7 IDEA | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO O | COMPLETED CAUSE OF DEA | TN (ITEM 27) (%pa | Print) | 1000 | , | | | سدد ب | 1110 | \dashv |
| | DR TROUBLE | J. Tel. | 1100 | 111 | 500 W | .Vr | | 0 | -11 | DV1V | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TUBE | 111 | 200 W | - VI) | VE | 16 | 1 4 | I KWY. | |
| | DFC 13 1990 4d | | | | | | | | | | |
| | H DELIK IMMH <i>Cha</i> i | A コッピ RE LPI (G /16)パマードパリング) | V | | | | | | | | |

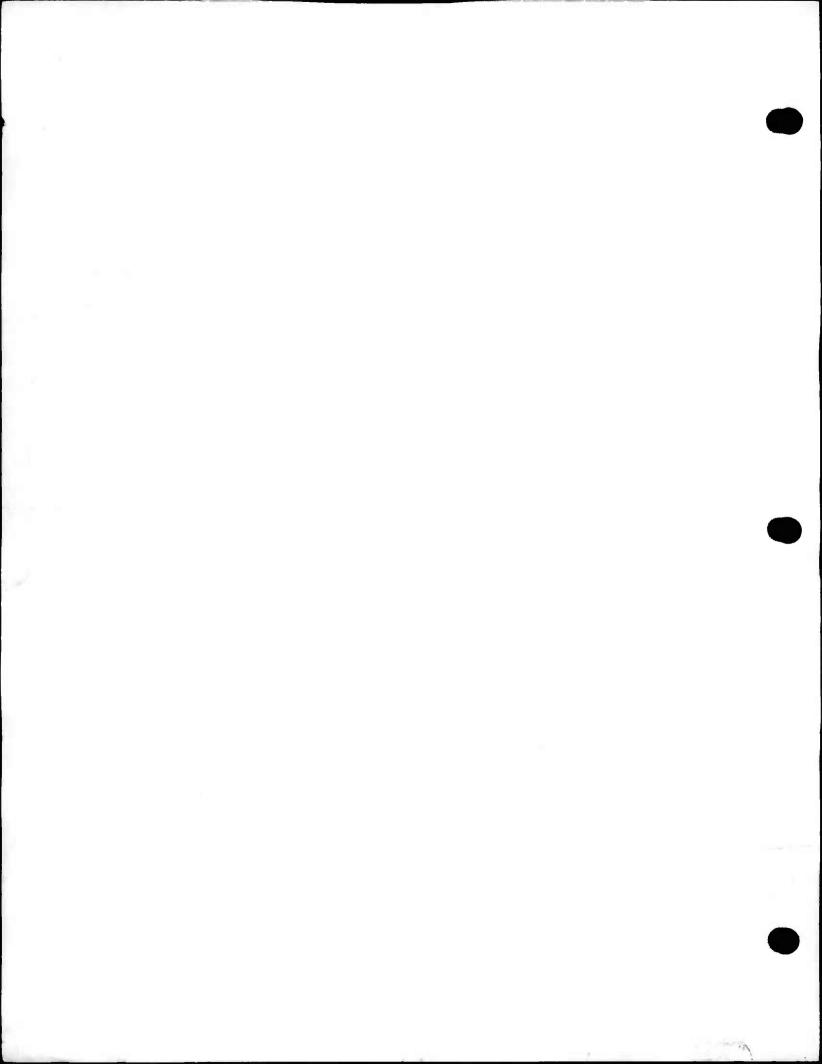




| hos | URECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached by the funeral director, page 5 should be detached by the funeral director. | Se. |
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| NDI | R: A | |
| ATTE | CLO S | 1 28 |
| THE OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 - Jurs after death. Page 6 may be retained by the host | URECTOR: After this certificate has been signed by the attending physician and completely filled in by the factor of the factor of the factor of Health and Mental Horiene niter to build cremation, or removal. | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| -15 | 35.5 | 2 25 |

| OR TATE EGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYG REG. | |
|-----------------------------------|--|--------------------|---|
| DENT'S NAME (First, Middle, Last) | | 2. DATE OF DEAT | Н |

| | FOR STATE OF MARYLANI 1 - REGISTRAR | | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN | E | , 011.0 | | | | |
|-----------------|---|---|--|--|---------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | | | |
| | Otsego Anderson | | | December | 2 1990 EAR | 1:30 P _M | | | | |
| | | s. last birthday) IF UN | DER 1 YEAR IF UNDER 24 HRS. S DAYS HOURS MIN. | 7. DATE OF BIRTH | | THPLACE (State or Foreign | | | | |
| | 216-10-9989 A 1 🖾 M 2 🗆 F | (Month, Dey, Year) Country) 07/01/1902 Maryland | | | | | | | | |
| DIRECTOR | Maryland General Hospital | 90.0 | Baltimore Ci | | SE. COUNTY OF | DEATH | | | | |
| [[| RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY | 10c CITY TOW | N OR LOCATION | | | 10d. INSIDE CITY | | | | |
| <u>E</u> | | | | | | LIMITS? | | | | |
| | Maryland 100. STREET AND NUMBER | Balt | imore I 10f. ZIP CODE | | I 100 CITIZEN OF | 1 XYES 2 NO | | | | |
| FUNERAL | | -1 3 -1 (| 21221 | | | | | | | |
| Z | 201 North Washington Stre | | 007 21231 33. WAS DECENOENT OF NISPA | NIC OBIGIN2 (Specify Ver | | CE — American Indian, | | | | |
| | 1 Never Married 2 Married FORCES? 1 YES 2 | NO | If yes, specify Cuban, Mexic 1 VES 2 NO Speci | an, Puarto Ricen, atc.) | Bi | eck, White, atc. | | | | |
| à l | 3 X Widowed 4 Divorced | ' | 1 1E3 2 110 Speci | η. | 30 | Black | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | a. DECEDENT'S USUAL | OCCUPATION ne during most of working | 16b. KIND OF BU | SINESS/INDUSTRY | | | | | |
| | Elementary/Secondary (0-12) College (1-4 or 5 +) | life. Do NOT use retire | d.) | | | | | | | |
| MP | | Labore | • | Revere | Brass | & Copper | | | | |
| COMPLETED | 17. FATNER'S NAME (First, Middle, Last) | 110-140-160 | 18. MOTNER'S N | AME (First, Middle, Maiden | Surname) | | | | | |
| BE (| John Edward Anderson | | Annie | Louise 3 | Johnson | 1 | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING AODR | ESS (Street and Number or Rural | Route Number, City or Tow | n, State, Zip Code) | | | | | |
| - | Roosvelt Anderson | | <u>ville, Mary</u> | land | | | | | | |
| | XXBurial 2 Cremation 3 Removal from State oth | ACE OF DISPOSITION per place) | (Name of cemetery, crematory or | | CATION — City or | | | | | |
| | 4 Donation 5 Other (Specify) Ar | | emorial Par | | | County, M | | | | |
| | 21. SIGNAL ONE OF FUNERAL SERVICE LICENSEE | | | Nutte | | ral Homes, | | | | |
| | Hubert E. nut | ton | 2501 Gwynn Baltimore, | Maryland | arkway 2121 | 6 | | | | |
| | 23. PART I. Enter the diseases, or complications that ceused the shock, or heart failure. List only one cause on each | | ter the mode of dying, au- | ch as cardiac or resp | iratory arreat, | Approximete Interval Between | | | | |
| | IMMEDIATE CAUSE (Final | maumania | (Aanimatian) | | | Onset and Death | | | | |
| | disease or condition Massive Pneumonia (Aspiration) | | | | | | | | | |
| | OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| S | Sequentially list conditions, OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| E | if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| 띮 | CAUSE (Disease or Injury that Initiated evente DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | |
| | PART II. Other eignificent conditions contributing to death but r | not resulting in the | underlying ceuse given in | Part i. 24s. WAS AP | | 24b. WERE AUTOPSY FINDINGS | | | | |
| CAL | | | | PERFO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| | | | | 1 TYES | DENO | DF DEATH? 1 YES 2 NO | | | | |
| PHYSICIAN: MEDI | | · | | - | | 1 123 2 110 | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | 28. PLACE OF DEATH (C | heck only one) | | | | | | |
| Sic | EXAMINER? 1 ☐ YES 2 ☐ NO HOSPITAL: 1 ☐ YES 2 ☐ NO 1 ☐ ER/Outpetle | | fER: Nursing Nome 5 ☐ Rasidanca | 6 Other (Specify) | | | | | | |
| Ŧ | 27. MANNER OF DEATN 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCURED | | | | | |
| ВУР | 1 Natural 5 Pending 2 Accident Investigation | INJUNT I | 1 YES 2 NO | | | | | | | |
| | 3 Suicida 6 Could not be 26e. PLACE OF INJURY — building, atc. (Specify) | At homa, farm, street, | factory, offica | 28f. LOCATION (Street City or Town, State | and Number or Rui | ral Route Number, | | | | |
| COMPLETED | 4 Homicide determined | | | | | | | | | |
| 7 | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge | ge, death occurred at t | he time, data and place, and du | ra to the cause(a) and ma | nner as stated. | | | | | |
| OM | one) 2 MEDICAL EXAMINER: On the basis of examination an | nd/or investigation, in | ny opinion, death occured at th | e time, data and place, a | nd dua to the caus | se(a) and manner as atated. | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NI | JMBER | | IEO (Month, Day, Year) | | | | |
| O BE | Sunten foury. Intern | | N/A | | 11/2/ | 60 | | | | |
| 2 | 30. NAME AND AGORESS OF PERSON WNO COMPLETED CAUSE OF GEATN | | 1 / 1/ 1: | 7 (| | | | | | |
| | CHISTEN FANG 70 Mary | | eneal Hospi. | th (| | | | | | |
| | DEC 1 3 1990 File Said Said Con To | IRE | , | | | | | | | |
| | DEU - U IJJU JUNGUNGON-AGY | ndella | | | | | | | | |



BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS. P.O. BOX 13146.

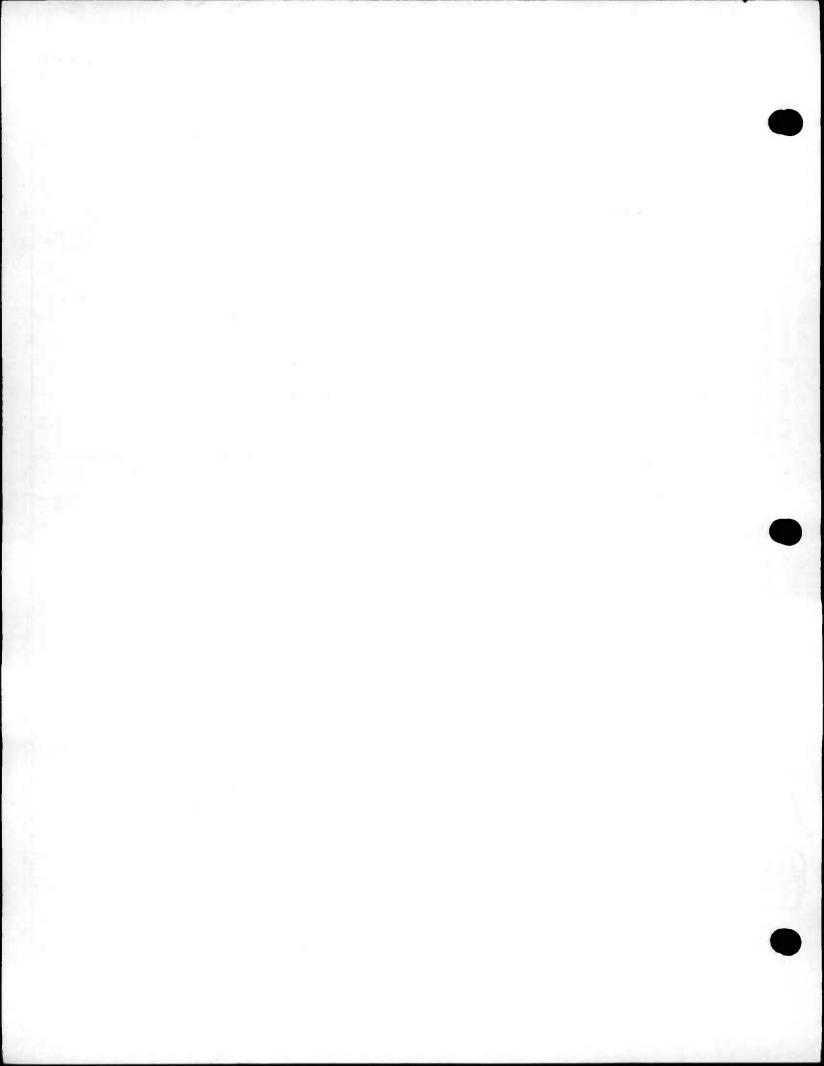
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| | DUVCICIAN. |
| | N OD ATTENDIAD DUVELLAN. The law remires that the death certificate he exercised within |
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| | - |

30. NAME AND ADDRESS OF PER DECEMBER 11. DATE FILEO (Month, Day, Year)
DEC 1 3 1990

| HYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by the hospital or attending physician. | his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should with the state Dent, of Health and Mental Horison prior to burial cremation, or removal. | ked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| TO THE SHITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exec | The FONERAL DIRECTOR: After this certificate has been signed by the attending physician and | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumati |

| | FOR 1 STATE | STATE OF MARYLAND / | DEPARTMENT | OF HEALTH AND I | MENTAL HYGIENE | 90 | 34147 | | | |
|-----------------------|--|--|---------------------------|--|--|----------------------|--|--|--|--|
| \neg | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) | | ERTIFICATE | | REG. NO. | | TIME OF DEATH | | | |
| | John La | EE BAHL | e Se | | MONTH DAY | YEAR | LI: MON | | | |
| | 477111 | 5. SEX 8. AGE (In yrs. las | st birthday) IF UNDER 1 | YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | ACE (State or Foreign | | | |
| | 243-38-6052 | 18 M 2 D F 70 | YRS. MONTHS | DAYS HOURS MIN. | (Month, Day, Year) 7/6/20 | Country) | arolina | | | |
| | 9a. FACILITY NAME (If not institution, give stre | net and number) | 9b. CITY, T | OWN OR LOCATION OF DE | EATH 9c. C | OUNTY OF DEAT | | | | |
| DIRECTOR | ST AGNES | Lospital | Da | Itimore, | MA | Balti | more | | | |
| REC | 10a. STATE 10b. COUNTY | | 10c, CITY, TOWN OR | LOCATION | .10 | 10 | d. INSIDE CITY LIMITS? | | | |
| | MD | | Bal | timore | MD | | YES 2 NO | | | |
| FUNERAL | 10e. STREET AND NUMBER | er Stree | -1 | 10f. ZIP CODE | 226 | CITIZEN OF WHA | T COUNTRY? | | | |
| 빌 | | 12. WAS DECEDENT EVER IN U.S. AF | DMED 19 W | AS DECEMBENT OF HISPAN | IC ORIGIN? (Specify Yea or No | U.S.A. | American Indian, | | | |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES 2 I | NO If | res, specify Cuban, Maxica YES 2 NO Specify | n, Puarto Rican, atc.) | Black, W Specify: | hite, etc. | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or | | ECEDENT'S USUAL OCC | | 16b. KIND OF BUSINESS | /INDUSTRY | | | | |
| 91 | Elementary/Secondary (0-12) | | s. Do NOT use retired.) | | - 15 A | | | | | |
| ₹ I | 4th grade | <u> </u> | <u>aintenan</u> | ce Worker | | | cating | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | THE SECTION AND ADDRESS. | ME (First, Middle, Maiden Surnan | 10) | | | | |
| B | Johnnie Battle 19a, INFORMANT'S NAME (Type/Print) | | A MANUAL ADDRESS / | | i Williams Route Number, City or Town, State | 7: 0-11 | | | | |
| 2 | Johnnie L. Bat | | | | The state of the s | | 21220 | | | |
| | 20s. METHOD OF DISPOSITION | 20b. PLACE | | | . Baltimor | | 21229 State | | | |
| | 20a. METHOD OF DISPOSITION 1 Name of cometery, crematory or other place) 20b. PLACE OF DISPOSITION (Name of cometery, crematory or other place) 20c. LOCATION — City or Town, Stata 20c. LOCATION — City or Town, St | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | AME AND ADDRESS OF FA | | | 1 Homes, | | | |
| | 10 | town 1 | 2: | 501 Gwyyn | ns Falls Pa Maryland | rkway | | | | |
| | 23. PÁRT I. Enter the diseases, or co | emplications that cansed the d | eath. Do not enter ti | he mode of dving, aud | Maryland h ea cerdiec or respiratory | ZIZIO | Approximate | | | |
| | shock, or heart failure. Li IMMEDIATE CAUSE (Finel | lat only one cause on each line | e. | | | | interval Between Onset end Death | | | |
| | disease or condition | WETAITAT | 76 1121 | 15 CARC | AMMA | | ones, one south | | | |
| | resulting in death) a. | DUE TO (OR AS A CONSE | EQUENCE OF): | 1 | | | | | | |
| z | C b. | PHYPERC | ALLEM | 11 | | | | | | |
| 일 | Sequentially list conditions, if any, leeding to immediate | DUE TO (OR AS A CONSE | EOUENCE OF): | | | | | | | |
| 2 | CAUSE (Discess or Injury | | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE | EQUENCE OF): | | | / | | | | |
| CERTIFICATION | d. | | | | | | | | | |
| - | PART ii. Other significant conditions | contributing to death but not | resulting in the und | erlying ceuse given in | Part I. 24s. WAS AN AUTOR PERFORMED? | | ERE AUTOPSY FINDINGS MILABLE PRIOR TO | | | |
| 8 | | | | | 1 TES 2 D) | C C | OMPLETION OF CAUSE | | | |
| Ē | | | | | | | YES 2 NO | | | |
| ž | | | | | | | 8 | | | |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | OTHER: | 26. PLACE OF DEATH (C) | eck only one) | | | | | |
| YSI | 1 TYES 2 NO | 1 npetlent 2 ER/Outpetlent | 3 DOA 4 Nursin | ng Home 5 - Residence | | | | | | |
| BY PHYSICIAN: MEDICAL | 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 1NJURY M | RSC. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY | OCCURED | | | | |
| | 3 Suicide e Could not be determined | 26e. PLACE OF INJURY — At h building, atc. (Specify) | ome, farm, street, factor | y, office | 26f. LOCATION (Street and Nu City or Town, State) | mber or Rural Rou | te Number, | | | |
| COMPLETED | anal | DIAN: To the best of my knowledge, d | | | | | | | | |
| Ö | 2 MEDICAL EXAMINER | t: On the basis of examination and/or | r investigation, in my op | inion, death occured at the | time, data and place, and dua | to the cause(a) a | nd manner as stated. | | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER | MY ! | UD | 29c. LICENSE NU | MBER 29d. | DATE SIGNED (M | onth, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAMPS OF DEATH OF | | | | 14/0 | 0110 | | | |

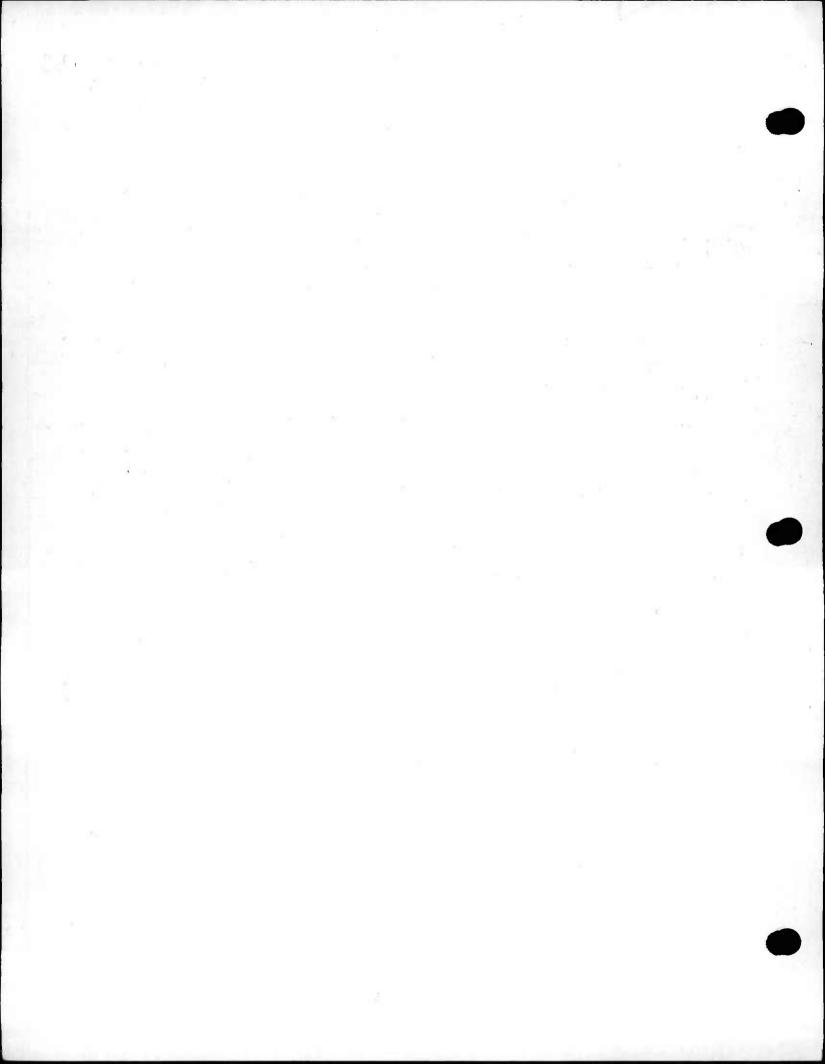
DHMH-18 Rev 1/89



Popular S. M. T. and

| ained by the hosp | should be detached | tiffed at once. |
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| age 6 may be re | director, page 5 | er must be no |
| ours after death. | I in by the funeral | nedical examin |
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this secretificate has been signed by the attentioning physician and completely filled in by the funeral director, page 5 should be detached the following the followin | be filed within 72 foots are deem with the State Debt. Of regularing mental hypers prior to buring, or lemovas. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| n certificate be exe | inding physician ar | or other trauma |
| ires that the death | signed by the after | ws any injury, |
| IAN: The law requ | rtificate has been | or item 23 sho |
| TENDING PHYSIC | OR: After this cer | 8 is marked, |
| HOSPITAL OR AT | FUNERAL DIRECT | Within /2 hours a TANT: If Item 2 |
| TO THE | THE THE | IMPOR |

| | FOR 1 - STATE REGISTRAR | | STATE OF I | MARYLAND A | DEPAR ERTIF | | | | | | HYGIEN REG. NO. | E | U | 34140 |
|--------------------|---|--|------------------------|-------------------------------|---------------------------|--------------------|-----------|--------------------------|--|------------------------|--------------------|------------|----------|--------------------------------------|
| | 1. DECEDENT'S NAME (First, | Miridia Last) | | | | IOAH | _ 01 | DLA | | 2. DATE OF | | | | 3. TIME OF DEATH |
| | | LIZABI | ETH | 1 | BER | KEI | VKE | EMP. | ER | DECEMBER 9,1990 1035 A | | | | 1035 A M |
| | 4. SOCIAL SECURITY NUME | ER | 5. SEX | 8, AGE (In yrs. le | | | | | 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) | | | | | |
| | 226 01 8758 1 M 2 XF 79 | | | | YRS. | MONTHS | DAYS | HOURS | | April | | | Vi | rginia |
| Стря | 9e. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL | | | | | 1 | | DE LOCATI | | HTA | | 9c. COUN | | |
| Ö, | PENINSULA | | KAL HOSPI | LTAL | | SE | ALIS. | BURY | , MD | | | WIC | OMIC | ,0 |
| C DIRECTOR | 10e. STATE | 10b. COUNTY | Y | | 10c. C/1 | ry, TOWN | OR LOCAT | TION | | | | | | 10d. INSIDE CITY |
| | Maryland | Worce | ester | | Oc. | ean (| City | | | | | | | 1 X YES 2 NO |
| K | 10e. STREET AND NUMBER | | | | | | 101 | . ZIP COD | E | | | 10g. CITI | ZEN OF V | VHAT COUNTRY? |
| FUNERAL | 214 Somerse | t Stre | eet | | | | 2 | 1842 | | | | U. | S.A. | |
| 5 | 11. MARITAL STATUS | | | T EVER IN U.S. M | | | | | | NC ORIOIN? (| | or No- | 14. RACE | — American Indien, k, White, etc. |
| BX | 1 Never Married 2 3 | | | MAR OR DATES | | | 1 TYES | 2XXNO | Specify | y: | arr, atta, | | Speci | T 77 A . |
| | | EDENT'S EDU | | (0 | ECEDENT'S Sive kind of | work done | during mo | ON ost of workl | na | 18b, K | IND OF BUS | SINESS/IND | USTRY | |
| COMPLETED | Elementary/Secondary (0 | 7 | College (1-4 or 5 | +) | . Do NOT L | , | | | | | | | | |
| 2 | 7 yrs. | | | Sea | mstr | ess | | | | | wing | | | |
| | 17. FATHER'S NAME (First, M Chestney E | | -0 w to -0 | | | | | | - | ME (First, Mid | | | | |
| H | 190, INFORMANT'S NAME (1 | | wartz | | | | | | ttie | | Unkn | | | |
| ٩ | John Decker | | <u>.</u> | | | | | | | Aoute Number Ocean | | | | 1842 |
| | 20s. METHOD OF DISPOSIT 1. Burlei 2 ☐ Cremetic 4 ☐ Donetion 5 ☐ Other | n 3 🗆 Rem | oval from State | 20b. PLACE other p Suns | decel | | | | matory or | | | cation — | - | 21811 |
| | Sunset Memorial Park Berlin, MD 21811 21. SIGNATURE OF FACILITY 108 Williams St. | | | | | | | | | | | | | |
| | Burbage Funeral Home Berlin, MD 21811 | | | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Cause Court put to Source and Death May | | | | | | | | | | | | | |
| NO | disease or condition a. Carden Coreff getter Coreff med Dasel May Due to (or as a consequence of): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| CATI | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | | | |
| CERTIFICATION | that initiated events reculting in death) LAST | | | | | | | | | | | | | |
| C | PART II. Other significa | ent condition | ne contribution to | death but not | regulting | In the u | ndarlyln | C COURS | alven In | Part I 2 | de Was AN | AUTODEV | 241 | WEDE ALTOREY EINDANGE |
| PHYSICIAN: MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 MO 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | | | | |
| ż | | | | | | | | | | | | | | |
| S | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | HOSPITAL: | | | ОТНЕ | | LACE OF I | DEATH (Ch | neck only one) | | | | |
| YSI | 1 TES 2 NO | | inpatient 2 | ☐ ER/Outpatient | 3 🗆 DOA | | | ne 5 🗆 R | leeldence | 8 🗆 Other (| Specify) | | | |
| | | Pending Investigation | 28e. DATE O (Month, | F INJURY Day, Year) | 28b. Til | ME OF JURY M | W | JURY AT DRK? YES 2 | _ NO | 28d. DESC | RIBE HOW | INJURY OC | CURED | |
| TED BY | p C Outside - | 2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) City or fown | | | | | | | | or Rural | Route Number, | | | |
| COMPLETED | onel | | ER: On the best of | | | | | | | | | | | a) and manner as stated. |
| 8 | 29b. SIGNATURE AND TITU | OF CENTIFIE | 101 | ue. | | m | 1 | 29c. LIC | oa a | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| | 30. NAME AND ADDRESS OF PURSON WIND COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |
| 5 | 30. NAME AND ADDRESS O | | O MPLETED CAL | | EM 27) (Typ | oe, Print) | 2 | | <u></u> | 100 | 6 | 11 | 111 | 0 |



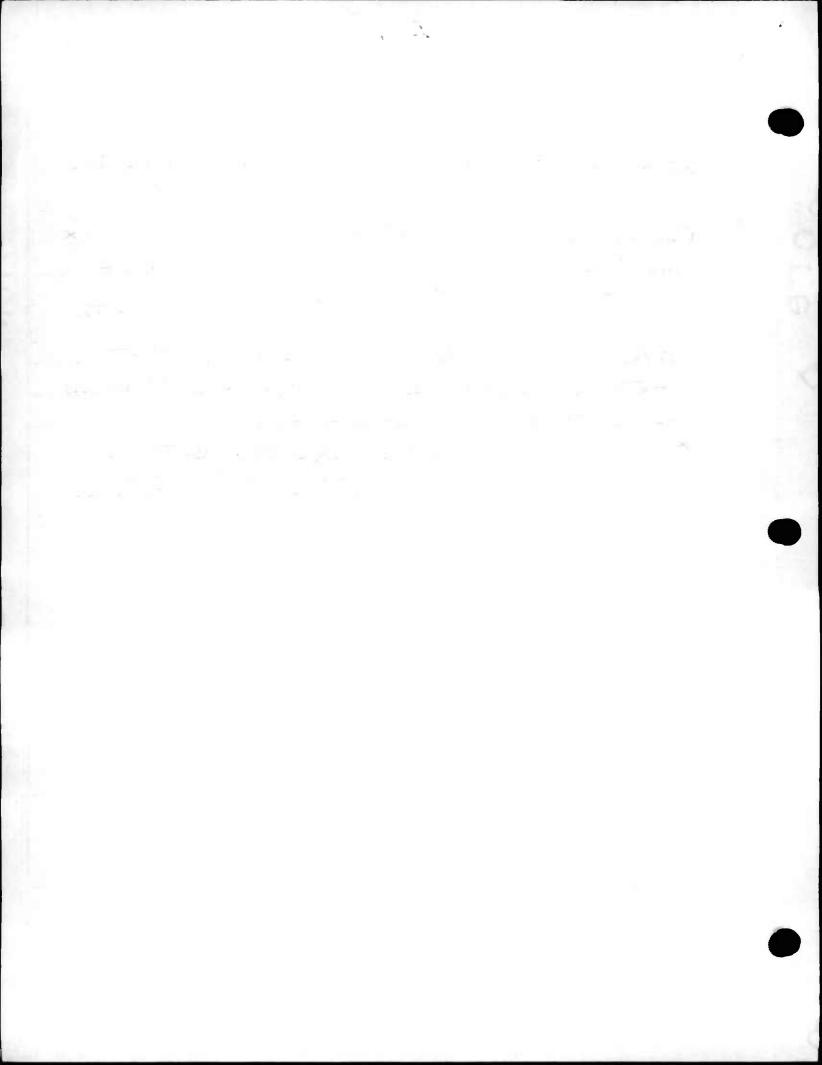
| TO BE COME | ION |
|---|--|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| ne funeral director, page 5 should be detained al. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| r death. Page 6 may be retained by the host | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2- viours after death. Page 6 may be retained by the breag |

31. DATE FILED (Month, Day, Year)
DEC 1 3 1990

32. REGISTRAR'S SIGNATURE

| | | | | | | 20 | 09192 | | |
|------------------|---|--|--|---|---|---------------------|--|--|--|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / | | OF HEALTH AND I | MENTAL HYGIEN REG. NO. | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF OEATH | Y YEAR | 3. TIME OF DEATH | | |
| | Steven | Charles | Boemme | 1 | 12-10-90 | | 11:40PM M | | |
| тов | 4. SOCIAL SECURITY NUMBER ALSO 415 55 28 | 5. SEX 6. AGE (In yrs. last | YRS. MONTHS | DAYS HOURS MIN. | 4 6 - 4 - 4 | 1948 19 | ATHPLACE (State or Foreign unity) ARYLAND | | |
| | 9a. FACILITY NAME (If not institution, give sin Rt. 40 East, Eas | | | Baltimore (| | Balti | more County | | |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | | | | | 1 | | |
| FUNERAL DIRECTOR | OARYLAND BALT | Timore | 10c. CITY, TOWN O | Δ | 2 | too CITIZEN O | 10d. INSIDE CITY LIMITS? 1 YES 2 NO OF WHAT COUNTRY? | | |
| NERA | 1431 MOHR'S | | | 2122 | 0 | U- | S.A. | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES 2 N IF YES, GIVE WAR OR OATES | 10 11 | NAS DECENDENT OF HISPAN I yea, specify Cuban, Maxice YES 2 NO Specify | n, Puerto Rican, atc.) | В | ACE — American Indian, lack, White, etc. | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade of | ATION 16a. DE (G | CEDENT'S USUAL OC ve kind of work done of Do NOT use retired.) | CCUPATION furing most of working | 16b. KIND OF BUS | SINESS/INDUSTR | Y 172 | | |
| COMPLETED | Elementary/Secondery (0-12) | College (1-4 or 5+) | Do NOT use retired.) | | 50 100 | X1 812 | 7.00 | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | 011112 | | ME (First, Middle, Maiden | Surname) | 01 101 | | |
| BE C | ARTHUR | n. Bornn | 1 | REC. | I Ainis | . MAC | DODALO | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | | (Street and Number or Rural | Route Number, City or Tow | n, State, Zip Code, | | | |
| 2 | FAMILY RECO | 205 | SANS | - AS ABO | 145 | | | | |
| | 20a, METHOD OF DISPOSITION 20a, METHOD OF DISPOSITION 20b, PLACE OF DISPOSITION (Name of cametery, cramatory or the place) 4 Donetion 5 Other (Specify) 20c, LOCATION — City or Town, State 4 Donetion 5 Other (Specify) | | | | | | | | |
| | 21. SIGNATURE OF PUNERAL SERVICE LICI | ENSEE | 22. 1 | NAME AND ADDRESS OF FA | ST OF ME | mai: | c | | |
| | > Italy 45 | None, In | 5 2 | rans chare | ORO ROPE | - PAR | Krisse | | |
| | 23. PART I. Enter the diseases, or co | omplications that caused the de | eth. Do not anter | the mode of dying, suc | h as cerdiec or resp | retory erreat, | Approximate | | |
| | ahock, or heart fellure. List only one dause on each line. Interval Between IMMEDIATE CAUSE (Final | | | | | | | | |
| | disease or condition a Multiple injuries | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| N | Sequentially list conditions, | | | | | | | | |
| ERTIFICATION | If any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | |
| 윤 | CAUSE (Diseese or Injury that initiated events | DUE TO (OR AS A CONSE | DUENCE OF): | | | | | | |
| E | resulting in death) LAST | | | | | | | | |
| S | | | | | | | 1 | | |
| Ä | PART II. Other significant conditions | econtributing to death but not i | eaulting in the un | deriying ceuse given in | Pert I. 24a. WAS AN PERFOI | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | |
| MEDICAL | · | | | | XX YES | NO D | OF DEATH? | | |
| | | | | | _ | | XIX YES 2 - NO | | |
| PHYSICIAN: | | | | | | | | | |
| C | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | OTHER | | | | | | |
| ΥS | 27. MANNER OF OEATH | 1 Inputient 2 ER/Outputient 3 | 26b, TIME OF | sing Home 5 - Residence | 6) Other (Specify) 28d. OESCRIBE HOW | Scene | 0 | | |
| BY PI | 1 Natural 5 Pending | 12000000000 | 10.34PI | 28c. INJURY AT WORK? 1 VES 2 NO | | | k by pick-up | | |
| B | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — At he building, etc. (Specify) | rme, ferm, street, fact Road | | 261. LOCATION (Street Rt-City or 470 Pr. Este | | nel Route Number, enezer Rd.Balt | | |
| ET | 29a. CERTIFIER | | | | County, Ma | ryland | | | |
| COMPL | (Check only | CIAN: To the best of my knowledge, de | | lme, date and place, and du | a to the cause(a) and me | nner as stated. | under and manner are stated | | |
| 8 | 1 / 1/ | : On the basis of examination and/or | veetryetton, in my c | | | | | | |
| BE | age strongty sie AND TITLE OF CESTIFIES | | | OCME | MBER | | NED (Month, Day, Year) 12-11-90 | | |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DEATH AT | M OT Char Divis | OCPIE: | | | 12 11 70 | | |
| . | FRANK PERETTI, MD | | | Street, Bal | timore, MD | 21201 | v | | |

OHMH-16 Rev 1/89



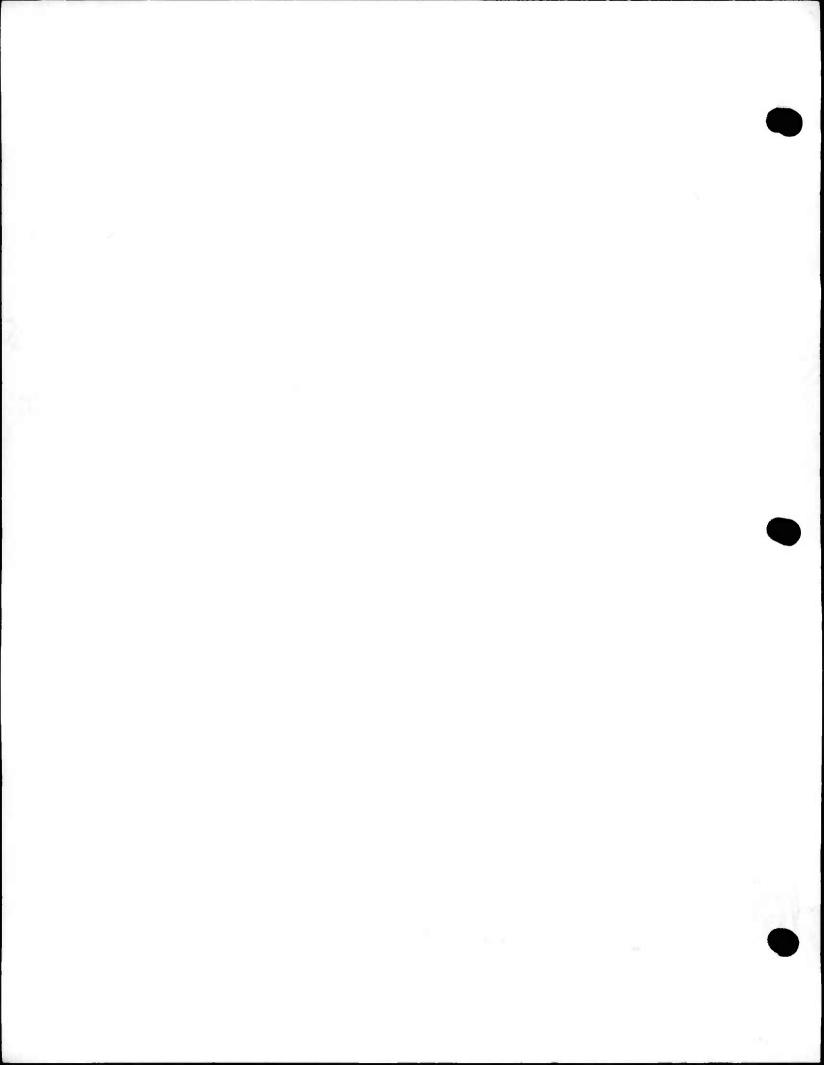
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \$2 mounts after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the builal-transit permit. Pages 1, 2, 3 should filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to builal, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND | D / DEPARTMENT | OF HEALTH AND | MENTAL HYGIENE |
|-------------------|----------------|---------------|-----------------------|
| | CERTIFICATE | OF DEATH | DEC NO |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTM | MENT OF HEALTH AND MEATE OF DEATH | ENTAL HYGIENE REG. NO. | 90 | 34150 | |
|---------------|--|--|---|--|----------------------------------|--|--|
| - | 1. DECEDENTIS NAME (First, Middle, Last) Willie EE 4. SOCIAL SECURITY NUMBER | BOWLES 5. SEX 6. AGE (In yrs. last birthday) 8 | | 2. DATE OF DEATH DAY / 2 / / / / / / / / / / / / / / / / / | 90 | 3. TIME OF DEATH 945 A M IPLACE (State or Foreign | |
| | 318-09-9183 9. FACILITY NAME (If not Institution, give str | 1 □ M 2 AF 83 YRS. MC | ENTHS DAYS HOURS MIN. | (Month, Day, Yeal) | 9c. COUNTY OF D | "G4. | |
| TOR | W-WOIDALE | Hospice Eutowill | BALTIMOR | 5 | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | 10c. CITY, T | TIMORE | = | | 10d. INSIDE CITY LIMITS? 1 1 YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER | uviin St | 101. ZIP COOE | | 10g. CITIZEN OF V | WHAT COUNTRY? | |
| BY FUNE | 11. MARITAL STATUS 1 Hever Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ADMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANI If yes, specify Cuben, Mexicen 1 YES NO Specify: | , Puerto Ricen, etc.) | or No— 14. RACI Black Spec | E – American Indian, k, White, etc. | |
| ETED | 15. OECEOENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12) | ATION College (1-4 or 5 +) ATION College (1-4 or 5 +) ATION (Give kind of word life. Do NOT use for the college (1-4 or 5 +) | t done during most of working etired.) | 16b. KIND OF BUS | NESS/INDUSTRY | Dace | |
| BE COMPL | 17. FATHER'S NAME (First, Middle, Last) | Kei | 16. MOTHER'S NAM | E (First, Middle, Maiden S | SBOVS | 5 | |
| 5 | 0 . Stokes | LPN 1214 | Eutaw Pla | CE BAL | LTO. N. | ld. 21217 | |
| | 20e. METHOO OF OISPOSITION 1 | wal from State other place) Western | ON (Name of cometery, crematory or | Ca- | ATION — City of To | own, State | |
| | 21. SIGNATURE OF FUNEBAL SERVICE LIC | WOUNDE | 22. NAME AND ADDRESS OF FAC WILLIAM C 1206 N NOR | BROWN | F.H. | D. Md 21217 | |
| | | omplications that caused the death. Do not list only one cause on each line. | | | | Approximata Interval Batween | |
| | disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE OF): | lu carde | ouve | ump | Herre | |
| NO | Sequentially list conditions, if sny, leading to immediate | DUE TO (OR AS A CONSEQUENCE OF); | voculus ? | deven | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | |
| | | s contributing to death but not resulting in | the underlying cause given in I | Part i. 24e. WAS AN | ALITOPSY 24 | b. WERE AUTOPSY FINDINGS | |
| MEDICAL | Status | decubilis i | bone the | PERFORI | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | ampulation 2 | 28. PLACE OF DEATH (Che | ck only one) | | | |
| YSIC | EXAMINER? 1 YES 2 NO | 1 Inpatient 2 ER/Outpatient 3 DOA 4 | OTHER: | | | | |
| ВУ РН | 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR | OF 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HOW IN | JURY OCCURED | | |
| | 3 Suicide 6 Could not be datermined | 26e. PLACE OF INJURY — At home, farm, strubuliding, atc. (Specify) | eet, factory, office | 28t. LOCATION (Street at City or Town, State) | nd Number of Rural | Route Number, | |
| COMPLET | One) | CIAN: To the best of my knowledge, death occurred R: On the basic of examination end/or investigation, | | | | e) end menner es stated. | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER THE STATE OF CE | ~ Muddesor | m 29c. LICENSE NUM | D 0 9 9 | ≥ 12- | 0 (Month, Day, Year) 11 - G () | |
| | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P | mo 924 | w, nor | th Au | Bulto.m | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | 21217 | |

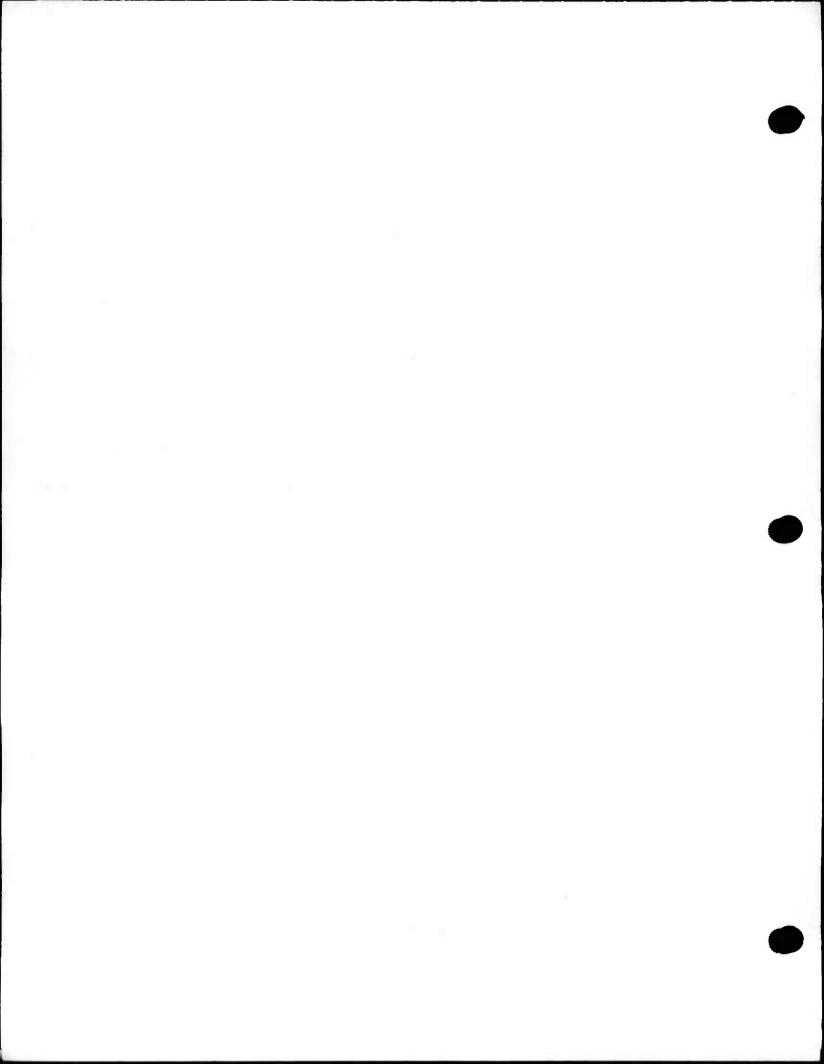


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| NO. | Afte | E . |
| EN | TOR. | 28 |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZA-mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached an attending the detached and the state of the | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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31. DATE FILED (Month, Day, Year)

DFC 1 3 1990

| | for 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPART | | | MENTAL HYG REG. | | 0 34151 |
|--|--|--|---|--------------------------------|-------------------------------------|-------------------------------------|------------------------|--|
| | 1, DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEAT | | 3. TIME OF OEATH |
| | CHARLES GETTIE BO | WLING | | | | | 1 90" | 12:05A M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTI (Month, Day, Ye | 8. | BIRTHPLACE (State or Foreign Country) |
| | 219 01 3842 | 1 📉 M 2 🗆 F | 72 YRS. | NONTHS DAYS | HOURE MIN. | 7/25/18 | | EST VIRGINIA |
| _ | 9a. FACILITY NAME (If not institution, give si | treet and number) | | 9b. CITY, TOWH | OR LOCATION OF DE | ATH | 9c. COUNTY | OF DEATH |
| 6 | VA MEDICAL CENTER | | | FORT HO | WARD | | BALTI | MORE |
| 딥 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | 10c. CITY, | TOWN OR LOCA | TION | · | | 10d, INSIDE CITY |
| DIRECTOR | MARYLAND BALTI | MORE | DIA | NDAIK | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | - | f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 8027 DELHAVEN ROA | D | | 2 | 1222 | | USA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II | N U.S. ARMED | | CENDENT OF HISPAN | | y Yaa or No- 14. | RACE — American Indian, Black, White, atc. |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | 1 TYPE | ecify Cuban, Maxica 2 NO Specify | n, Puerto Hicen, at C |) | Specify: |
| | 15. DECEDENT'S EDU | | | <u> </u> | ••• | T 401 11111 0 | | WHITE |
| COMPLETED | (Specify only highest grade | completed) | 16a. DECEDENT'S U (Give kind of we life. Do NOT use | ork done during m retired.) | ost of working | 2/25/07/19 19 | F BUSINESS/INDUS | IHY |
| 21 | Elementary/Secondary (0-12) | College (1-4 or 5+) | STEEL | | | | STEEL | |
| NO | 17. FATHER'S NAME (First, Middle, Last) | | 0,222 | VINA | | ME (First, Middle, M | aiden Surname) | |
| ŭ | JOHN BOWLING | | | | MARY | | STICE) | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | · | 19b. MAILING | ADDRESS (Street | and Number or Rural I | (3,3 | | de) |
| 2 | CLINICAL RECORDS | | 9600 N | ORTH PO | INT ROAD | , FORT H | OWARD MD | .21052 |
| | 20s. METHOD OF DISPOSITION 1 D Buriel 2 Cremation 3 Ram | 200 | b. PLACE OF DISPOSI | | | | c. LOCATION — City | |
| | 4 Donation 5 Other (Specify) | over from State | | LAND. | 5 | | BALTO. | mp. |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | ND ADDRESS OF FA | | | |
| | + Colt Con | rnelly | | CON | NC 114 F | unerAl | HOME | OF DUNBAIK |
| | 23. PART I. Enter the diseases, or | complications that cause | d the death. Do no | ot enter the m | ode of dying, suc | h sa cardisc or | reapiratory arrest | , Approximate |
| | shock, or heart failure. iMMEDIATE CAUSE (Final | List only one cause on e | each line. | | | | | Interval Between Onset and Death |
| | disease or condition resulting in death) | END STAGE I | HEART FAI | LURE | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| Z | Sequentially list conditions, | b | | | | | | |
| Ĕ | if any, leading to immediate | | | | | | | |
| 2 | cause, Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | | | | | | | |
| CE | | d | | | | | | |
| CAL | PART ii. Other significant condition | _ | but not resulting is | the underlyi | ng cause given in | | REFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | CHRONIC RENAL FA | ALLURE | | | | 1 🗆 Y | ES 2 NO | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | _ 1 | | 1 TYES 2 NO |
| Ÿ | | | | | | | | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | PLACE OF DEATH (Ch | eck only one) | _ | |
| ΙΥS | 1 YES 2 NO | 1 Inpatient 2 ER/Out 28e, DATE OF INJURY | patient 3 DOA 26b, TIME | | me 5 - Residence | | () HOW INJURY OCCUI | 35D |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJU | JRY W | ORK? | 280. DESCRIBE | 10W INJUNI OCCU | ne D |
| BY | 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE OF INJUR | Y — Al home, farm, s | | | 291. LOCATION (| Street and Number or | Rural Route Number, |
| COMPLETED | 4 Homicide 6 Could not be | building, atc. (Spe | ecify) | | | City or Town, | State) | |
| = | 29a. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my know | eledge death occurs | d et the lime de | a and place, and due | to the course(s) or | d manner on stated | |
| MP | (Orlock Orly) | | | | | | | ause(a) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | 29c. LICENSE NU | | | IGNED (Month, Day, Year) |
| BE | I. | Bohnen | | | THE STATE IN | | | 2/11/90 |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | IO COMPLETED CAUSE OF O | EATH (ITEM 27) (Type, | Print) | 1 | | | |
| | | | | | | | | |
| 9600 NORTH POINT ROAD, FORT HOWA 31. DATE FILED (Month, Day, 1601) 31. DATE FILED (Month, Day, 1601) 4. DECISION R. S. SIGNATURE THE POINT ROAD, FORT HOWA | | | | | | (1) (1) | 1057 | |
| | 31. DATE FILED (Month, Day, Year) | 3. DEGISTAR'S SIG | NAT Andell | I LOTIAL | KOAD, FC | JKI HOWA | ND MD. Z. | 1052 |



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TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the single of the function of the property of the property of the standard of the attending physician and completely filled in by the functal director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Merital Hyglene prior to burial, cremation, or removal.

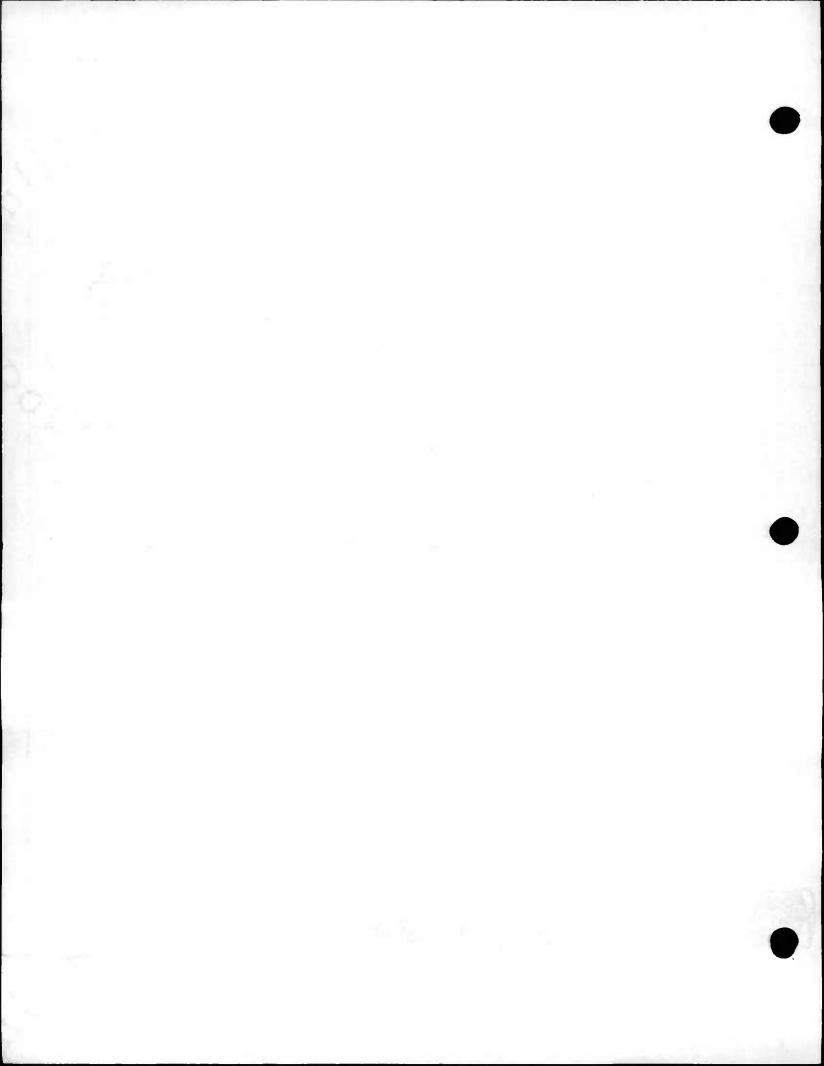
IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

34152 QN

| 1 - STATE REGISTRAR | STATE OF MARYLAN | ID / DEPARTM | | | MENTAL HYGIEN | | 04101 |
|---|---|--|--------------------|--------------------------------|--|---------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | 0211111101 | | | 2. DATE OF DEATH | AY YE | 3. TIME OF DEATH |
| Richard | | Carte | er | | 12 8 | | 10:44 P. M |
| 4. SOCIAL SECURITY NUMBER | | MON | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | C | HITTHPLACE (State or Foreign country) |
| 152-32-5048 9a. FACILITY NAME (If not institution, give s | 1 🖳 M 2 🗆 F 46 | | CITY TOWN O | R LOCATION OF DE | 10-06-4 | 96, COUNTY | N.J. |
| | | *** | | imore | Ain | 96. COUNTY | JF DEATH |
| 1512 N. ROSE S RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 40 - 4774 70 | OWN OR LOCAT | | | | 10d. INSIDE CITY |
| | ' | | | E, CITY | 7 | | LIMITS? |
| MD 10e. STREET AND NUMBER | | 27112 | | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 1512 N. ROSE S | TREET | | | 21213 | | U | SA |
| 11. MARITAL STATUS 1 Never Married 2- 1 Merried 3 Widowed 4 7 Torred | 12. WAS DECEDENT EVER IN U FORCES? 1 YES IF YES, GIVE WAR OR DATE | 2, 00 | If yes, spe | | HC ORIGIN? (Specify Yen, Puarto Rican, etc.) | | RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EDU (Specify only highest grade | CATION 1: | 6e. DECEDENT'S USU (Give kind of work | IAL OCCUPATIO | N at of working | 16b. KIND OF BU | SINESS/INDUST | RY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use ret | tired.) | | | | mar P |
| 11th 17. FATHER'S NAME (First, Middle, Last) | | UNEMP | LOYED | | ME (First, Middle, Malder | Sumamal | |
| ANDREW BROOK | INS | | | | CARTE: | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or To | | |
| BRENDA FIELDS | 205.5 | 713 CU | | | | ORE, M | ID. 21217 |
| 20a METHOD OF DISPOSITION 1 Description 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | ther place) | | | | · · | ORE, MD. |
| 21. SIGNATURE OF FUNERAL SERVICE LI | | | | D ADDRESS OF FA | CILITY | | |
| - Vanusau | Wad | | | | | | NORTH AVE. |
| 23. PART I. Enter the diseases, or shock, or heart failure. | complications that caused t List only one cause on aac | | enter the mo | de of dylng, suc | h se cerdiec or reep | olratory errest, | Interval Between |
| IMMEDIATE CAUSE (Final disease or condition | Margotic | Intoxic | ation | | | | Onset and Death |
| reaulting in death) | DUE TO (OR AS A C | | acion_ | | | | |
| Sequentially list conditions, | b | | | | | | |
| If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | | |
| CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A C | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| resulting in death) LAST | d | | | | | | |
| PART II. Other significant condition | na contributing to death but | not resulting in t | he underlyln | g cause given in | | N AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| | | | | | XX YES | | COMPLETION OF CAUSE OF DEATH? |
| | | | | | _ | | XXX YES 2 - NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | | | | | |
| EXAMINER? XIX YES 2 NO | HOSPITAL: | | THER: | ACE OF DEATH (Ch | 8 Other (Specify) | | |
| 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TIME O | F 28c. INJ | | 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| 1 Natural 5 Pending 2 Accident Investigation | found 12-8- | | | YES 2 NO | unknown | | |
| 3 Suicide 8 🔀 Could not be | 28e. PLACE OF INJURY - building, etc. (Specif) | At home, farm, street | et, factory, offic | • | 281. LOCATION (Stree City or Town, Stat | | Pural Route Number, |
| 4 Homicide determined | for | and at ho | me | | 1512 N. I | Rose St | ., Balto., Md. |
| (Marie Oray | ER: On the basis of examination | | | | | | suse(a) and manner as stated. |
| 296. SIGNATURE AND TITLE OF CENTIFIE | N. | | | 29c. LICENSE NU | | | GNED (Month, Day, Year) |
| | n, M.D. | | | , Balto. | | 1 | |
| 31. DATE FILED (Month, Day, Year): 14 | 32. REGISTRANS SIGNATURE | | | , | * en en en | | |
| DEC 1 3 | 990 gulia Dan | Mason-Nana | | | | | |



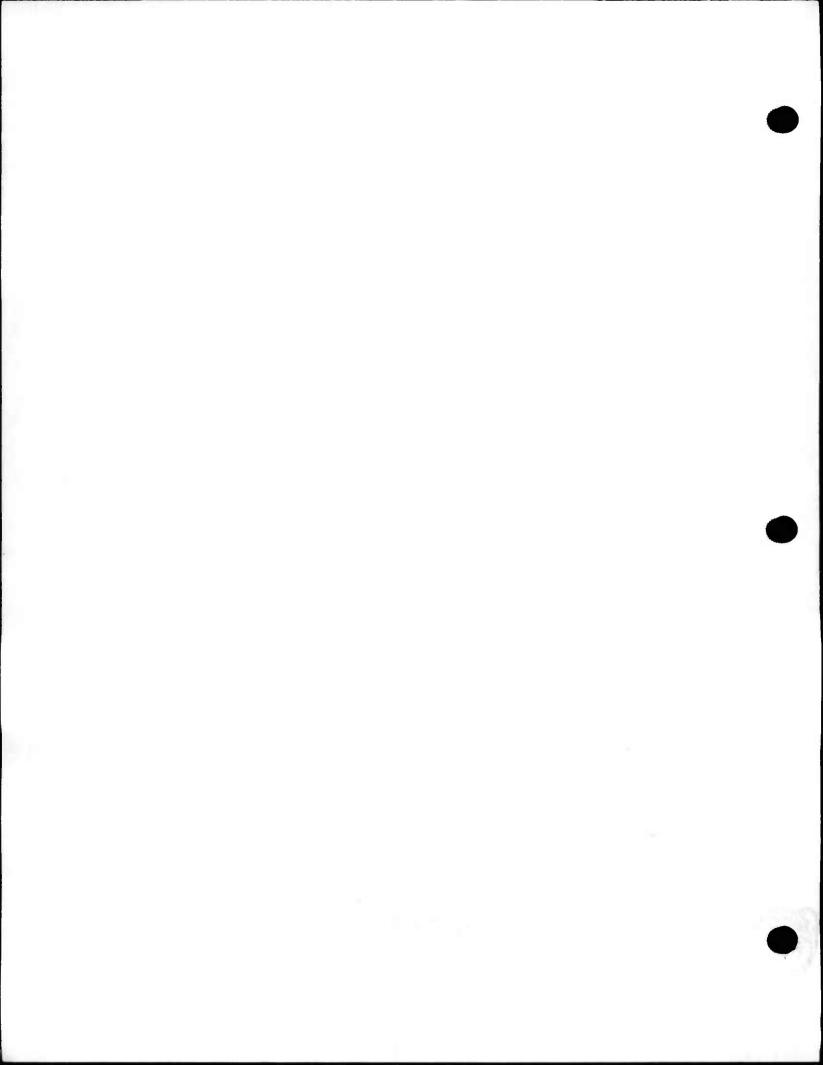


BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | FOR STATE REGISTRAR | STATE OF MARYL | | RTMENT OF | | MENTA | L HYGIENE REG. NO. | | | |
|------------------|--|---|------------------------------------|--|---|--|-------------------------------------|---|--|-------------------------------------|
| | DECEDENT'S NAME (First, Middle, Last) | Doris | | WKWELL | | De | cember | 7, 19 | 990 | 3:10 p m |
| | 4. SOCIAL SECURITY NUMBER 212-09-8058 | | (In yrs. last birthday) 85 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE (Mont | of BIRTH h. Day, Year) 2-1-19 | 05 | Cana | ACE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | 15 | 9b. CITY, TOWN | OR LOCATION OF DE | EATH | | 9c. COUNT | TY OF DEAT | Н |
| FUNERAL DIRECTOR | Franklin Square | Hosp | | Ros | sville | | | Ba | ltimo | re County |
| IREC | 10e. STATE 10b. COUNTY | altimore | 10c. CI1 | TY, TOWN OR LOC | ndalk -0 | Tray | Μληο | r | | d. INSIDE CITY LIMITS? |
| 10 | 100. STREET AND NUMBER | TTCTMOTC | | | ot, ZtP CODE | Jray | MAIIO | | | T COUNTRY? |
| ER/ | 218 Pinewood R | .d . | | | 21222 | | | U. | S.A. | |
| B | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced | FORCES? 1 YES 2 NO | | | DECENDENT OF HISPANIC ORIGIN? (Specify Year or s, specify Cuban, Maxican, Puerto Rican, etc.) YES 2 🔀 NO Specify: | | | | or No- 14. RACE — American Indian, Black, Whita, atc. Specify: WHite | |
| COMPLETED | (Specify only highest grade | only highest grade completed) ((| | CEDENT'S USUAL OCCUPATION ve kind of work done during most of working Do NOT use retired.) | | 161 | 16b. KIND OF BUSINESS/INDUSTRY | | | |
| APL. | Elementary/Secondary (0-12) Unknown | College (1-4 or 5+) Homemaker O | | | Own | Home | | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) UNKNOWN | | | 18. MOTHER'S NAME (First, Middle, Maiden Surname) Hannah Evans | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town, State, Zip Code) | | | | |
| 2 | George Cawkw | ell | 21 | 8 Pines | vood Rd. | D | undal | k M | d2 | 1222 |
| | 20a. METHOO OF DISPOSITION 1 | oval from State | b. PLACE OF DISPO | SITION (Name of c | emetery, crematory or | | 20c. LO | CATION — C | ity or Town. | State |
| | 4 ☐ Donatton 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Greenm | 22. NAME | cematory | CILITY | | lto. | | |
| | Bradley-Ashton Funeral Home, Inc. 2134 WIllow SPring Rd., Dundalk, MD | | | | | Inc. | | | | |
| CERTIFICATION | IMMEDIATE CAUSE (Final | oUÉ TO (OR AS | | estinal _{Pp:} | Bleed | | q | | | Interval Between Onset and Death |
| MEDICAL | Severe Dementia | re Dementia | | | | 24a. WAS AN PERFOR 1 YES 2 | MED? | CO | ERE AUTOPSY FINDINGS MAILABLE PRIOR TO DMPLETION DF CAUSE F DEATH? YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 011612 | | PLACE OF OEATH (CI | neck only o | nne) | | | |
| IXSI | 1 TYES 2 NO | 1 Inpatient 2XXER/Out | | | me 5 - Residence | | | | | |
| | 27. MANNER OF DEATH 1XX Natural 5 Pending trivestigation | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TI | IJURY V | JURY AT ORK? YES 2 NO | 28d. DE | SCRIBE HOW I | NJURY OCC | UREO | |
| TED BY | 2 Accident threstigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, atc. (Sp | Y — At home, term, ecify) | street, fectory, of | ica | | CATION (Street a or Town, Stete) | and Number of | or Rural Rou | te Number, |
| COMPLETED | CONDON ONLY | ICIAN: To the best of my kno ER: On the basis of examinati | | | | | | | | nd manner as stated. |
| TO BE C | 29b, SIGNATURE AND TITLE OF CENTIFIE | on Re | | - Pulsal | 29c. LICENSE NU 0126 | | | 29d. DATE SIGNED (Month, Day, Year) 2 - 7 - 90 | | 10nth, Day, Year) 7 - 90 |
| | Prudence Jackso | on, M.D. 900 | 00 Frank | lin Squa | re Drive | , Ba | 1timore | e, Ma | rylan | d 21237 |
| | DEC 13 199 | | NATUR JANGO | 5 | <u> </u> | | | | • | |





| 46 | physi |
|--------------------------------|---|
| BALTIMORE, MARYLAND 21203-3146 | nours after death. Page 6 may be retained by the hospital or attending physi- |
| 2 | 6 |
| VD 2 | hospital |
| A | the state |
| 7 | 3 |
| MAR | retained |
| | 8 |
| Ä, | тау |
| Ö | 9 |
| Ĭ | Page |
| ALT | death. |
| 8 | after |
| | Ours |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a product of the major of the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| _ | SCENENT'S NAME (First Middle I ant) | | 2 DATE C |
|---|-------------------------------------|--|----------|
| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M CERTIFICATE OF DEATH | MENTAL |
| | 012 21 12/21 0111 | | |

90 34154

HYGIENE

| | REGISTRAR | | CERTIF | ICATE | OF DEATH | REG. NO | O | |
|-----------------|--|---|---|--------------------------------|---|---|-----------------------------|---|
| | 1. OECEDENT'S NAME (First, Middle, Leat) WILLIE | COLEMAI | N | | | 2. DATE OF OEATH MDNTH 12/7/199 | DAY YEA | 3. TIME OF OEATH 11A.M. M |
| | 4. SOCIAL SECURITY NUMBER 212-09-6723 | | GE (In yrs. last birthday) | IF UNDER 1 Y | EAR IF UNDER 24 HRS. AYB HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 7 20/ 14 0 | INTHPLACE (State or Foreign country) ABAMA |
| NO BO | 90. FACILITY NAME (If not institution, give st 2546 W. FAYETT | 3051 10101 | | | WN OR LOCATION OF D | EATH | 9c. COUNTY | OF DEATH |
| ธ์ | RESIDENCE OF DECEDENT | | 1 | | | | | Lancation and |
| - DIRECTOR | MARYLAND 10b. COUNTY | | 1 | LTIMO | RE, MARYLA | ND | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| FUNERAL | 2546 W. FAYETTE A | | | AND | 101. ZIP CODE 21217 | | USA | OF WHAT COUNTRY? |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Divorced | 12. WAS DECEDENT EVE FORCES? 1 _ Y IF YES, GIVE WAR O | ES 2 V NO | If y | S DECENDENT OF HISPA ea, specify Cuben, Mexic YES 2 X NO Spec | en, Puerto Rican, etc.) | | RACE — American Indien, Black, White, etc. Specify: LACK |
| E | 15. OECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDENT'S (Give kind of life. Do NOT to | S USUAL OCCI work done duri | JPATION ing most of working | 18b. KIND OF B | USINESS/INDUST | RY |
| COMPLETED | Elementary/Secondery (0-12) 12 | College (1-4 or 5+) | LONGSHO | REMAN | To see and | | EEL | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | AME (First, Middle, Maide | | - 1 |
| BE | ISAIAH COLEM 190. INFORMANT'S NAME (Type/Print) | IAN | 19b. MAILIN | G ADDRESS (S | HENRI | | COLEMAN own, State, Zip Coo | le) |
| 임 | ELIZABETH COLEM | AN | 2546 | W. F | AYETTE ST, | BALTIMORE | . MARYL | AND 21223 |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo | oval from Stata | 20b. PLACE OF DISPO | SITION (Name | of cemetery, crematory or | 20c. I | LOCATION — City | or Town, State |
| | 4 Donation 5 Other (Specify) | ENSEE A | ARBUTUS | | IAL PARK ME AND ADDRESS OF F | | BUIUS, I | MARYLAND |
| | Hord V | n. Este | P | ES | TEP BROTHE | ERS FUNERA | L HOME, | P.A. MD. 21217 |
| 2 | ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | + la | vt Fac | lieve | | Interval Between Onset and Deeth |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | | | | | | | |
| AL C | PART II. Other algolificent condition | a contributing to dee | th but not resulting | in the unde | erlying ceuse given i | n Part I. 24a. WAS. PERF | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | - Heure | 1 | 1 YES | 2 Kn0 | OF DEATH? | | | |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF DEATH (| Check only one) | | |
| Z I | 1 YES 2 NO | 1 Inpetient 2 I ER/ | Outpatient 3 DOA | | g Home 5 Residenc | 8 Other (Specify) | | |
| BY PHYSICIAN: M | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJU (Month, Day, Ye | | ME OF 2 NJURY M | 8c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HO | W INJURY OCCUR | ED |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF IN. building, etc. | IURY — At home, ferm (Specify) | , street, factor | y, office | 28f. LOCATION (Stree City or Town, Str | | Rural Route Number, |
| COMPLETED | CONSULT ONLY | ICIAN: To the best of my I | | | | | | ause(e) and manner ee stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | F | MIN | | 29c. LICENSE N | UMBER / 72 8 2 | 29d. DATE S | IGNED (Month, Day, Year) |
| F | 30. NAME AND ADDRESS OF PERSON WIT | 1015+4 | PRAL | 2 A-1 | 10 BC | elfrina | re M | d 2122 > |
| | DEC 1 3 1990 | 32. JEGISTRAPIS | SIGNATURE (doon-Randal | ٤ | | | | |



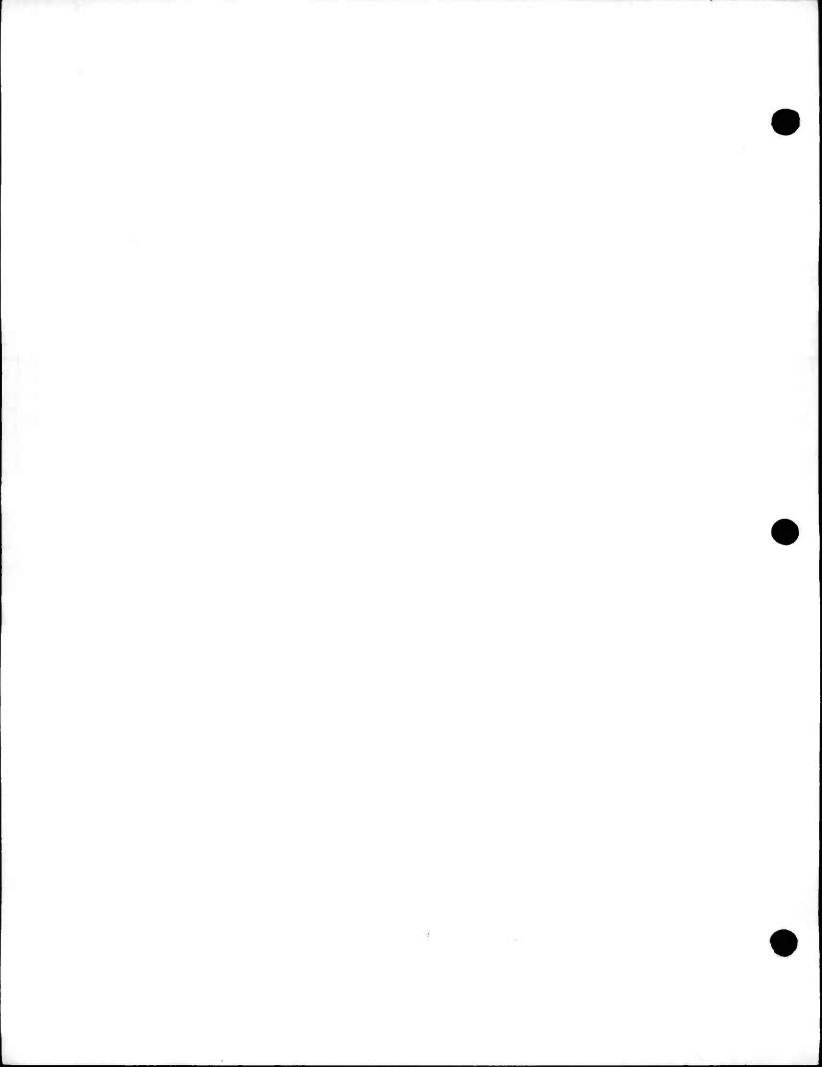
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permit. Pages 1, 2, 3 should

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit | be filed within 72 hours after death with the olate Dept. or hearth and Merital Hyglene prior to durial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|--|
| SPITAL OR ATTENDIN | NERAL DIRECTOR: Aft | hin 72 hours after de: | NT: If item 28 is n |
| TO THE HO | TO THE FUI | be filed with | IMPORTAL |

| | 1 - FOR STATE REGISTRAR | TE OF MARYLAND / DEPAR | TMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | 34155 | | | | | | | | | | |
|--|--|---|---|--|--|--|--|--|--|---------|---------------------------|-------------------------------|-----|----|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 3. TIME OF DEATH | | | | | | | | | | |
| | ALICE B. COY | | | 12 / 10 / | 90 8:18 P M | | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | | IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | | | | | | | | | |
| | 195-07-8177 101 | M 2 2 F 84 YRS. | MONTHS DAYS HOURS MIN. | 1-11-1906 | PENNA. | | | | | | | | | | |
| | 9a. FACILITY NAME (If not institution, give street and | number) | 9b. CITY, TOWN OR LOCATION OF DI | EATH 9c. COUN | TY OF DEATH | | | | | | | | | | |
| 5 | DULANCY-TOWSON | NURSING Home | TOWSON | 8 | ALTO. | | | | | | | | | | |
| DULANCY-TOWSON NURSING HOME TOWSON BALTO. RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION DULANCY-TOWSON NURSING HOME 10g. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | | | | | | |
| | | | | | | | | | | | 111 WEST RD. | | 212 | 04 | U.S.A. |
| | | | | | | | | | | FUNERAL | 11. MARITAL STATUS 12. WA | S DECEDENT EVER IN U.S. ARMED | | | 14. RACE — American Indian, Black, White, atc. |
| BYF | | PRCES? 1 TYES 2 THO YES, GIVE WAR OR DATES | If yes, specify Cuban, Maxica 1 YES 2 NO Specifi | | Specify: | | | | | | | | | | |
| | | | | 1 | WHITE | | | | | | | | | | |
| TED | 15. DECEDENT'S EDUCATION (Specify only highest grade complete | ed) (Give kind of v | USUAL OCCUPATION rork done during most of working e retired.) | 18b. KIND OF BUSINESS/IND | USTRY | | | | | | | | | | |
| | Elementary/Secondary (0-12) Colleg | | OUSEWIFE | | ·] | | | | | | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | ME (First, Middle, Maiden Sumame) | | | | | | | | | | | |
| | JAMES T. | PIPP | MARY | | UNCE | | | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 19b. MAILING | ADDRESS (Street and Number or Rural | | | | | | | | | | | | |
| 임 | DOROTHY MILLER | 202 (| SULL DRIVE | SOUTH DAYTUN | A BEACH FLA | | | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Durint 2 Cremation 3 Removal from | 20b. PLACE OF DISPOS other place) | ITION (Name of cemetery, crematory or | 20c. LOCATION — | | | | | | | | | | | |
| | 4 Donation 5 Other (Specify) | MEADO | WRIDGE CE | M. LAUR | el MD. | | | | | | | | | | |
| - 1 | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 11 | 22. NAME AND ADDRESS OF FA | / | | | | | | | | | | | |
| | Colt Con | nelly | connelly | Funeral Ho | NE of bundal | | | | | | | | | | |
| | 23. PART I. Enter the diseases, Dr complic shock, Dr heert failure. List Dn iMMEDIATE CAUSE (Finel disease Dr condition reaulting in death) | | ot anter the mode of dying, suc | n es cerdiac or respiratory arr | est, Approximate interval Between Onset and Death | | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF | j; | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other eignificant conditions control | ributing to death but not resulting i | n tha undarlying cause given in | Pert I. 24e. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | | |
| ż | | | | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | PITAL: | 26. PLACE OF DEATH (C) | neck only one) | | | | | | | | | | | |
| 2 | 1 TYES IT NO 1 In to | patient 2 - ER/Outpatient 3 - DOA | 4 ☐ Nursing Home 5 ☐ Realdence | | | | | | | | | | | | |
| 표 | 27, MANNER OF DEATH 1 Natural 5 Pending | 8a. DATE OF INJURY (Month, Day, Year) 28b. TIM | URY WORK7 | 28d. DEŞCRIBE HOW INJURY OCC | CURED | | | | | | | | | | |
| β | 2 Accident Investigation | | M 1 YES 2 NO | | | | | | | | | | | | |
| COMPLETED | 3 Suicide 8 Could not be 4 Homicide determined | 8a. PLACE OF INJURY — At homa, farm, a building, atc. (Specify) | Arest, factory, office | 281. LOCATION (Street and Number City or Town, State) | or Rural Route Number, | | | | | | | | | | |
| ا ۳ | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To | o the best of my knowledge, death occurre | ed at the time, data and place, and du | to the cause(a) and manner so stat | ed. | | | | | | | | | | |
| S I | contain only | he basis of exemination and/or investigation | | | EA and a second an | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c, LICENSE NU | | E SIONED (Month, Day, Year) | | | | | | | | | | |
| H | 9/1/101. | CANO | 115 | h3 4 1 | 21290 | | | | | | | | | | |
| ٥ | 30 MAME AND PODRESS OF PERSON WHO SOME | PLETED CAUSE OF DEATH (ITEM 27) (Typo) | Print) 20 Bel | an Rd ba | lli Ma >1236 | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 3 DEC 1 3 1990 | 2. REGISTRAR'S SIGNATURE Julia Davidson-Ronda | 2 | 2014 | | | | | | | | | | | |

34155



TO BE COMPLETED BY FUNERAL DIRECT

Hill Research

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

SIGNATURE AND TITLE OF CERTIFIER

| | | | | | | | 90 3415 |
|--|--|--|--|--|--|--|---|
| 1 - STATE REGISTRAR | STATE OF MARYLAND | | ENT OF HEAL | | ENTAL HYGIEN | E | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | - V | DATE OF DEATH | | 3. TIME OF DEATH |
| 7 ac Hary | SOLIDEO | CROC | nce | | MONTH D | 1990 | AR M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. | Inst bimbonic IE | UNDER 1 YEAR IF U | NDER 24 HRS. 7 | , DATE OF BIRTH | | BIRTHPLACE (State or Foreign |
| 4. SOURE SECONITY HOMBEN | 1 X M 2 F | | ITHS DAYS HOU | | (Month, Day, Year) | | Country) |
| | 1,55 M 2 L F | THS. | 2 | | MAYAL | 1000 | TARYLAND |
| 9e. FACILITY NAME (If not Institution, give s | treet end number) | 9b. | CITY, TOWN OR LO | CATION OF DEAT | Ή , | 9c. COUNTY | OF DEATH |
| 10025 ()AGI | SOT KOAD | | AROS | / | | BALT | 290mil |
| RESIDENCE OF DECEDENT | 201 11010 | | 21-110112 | | - | 10,10 | 11100 |
| 10a. STATE 10b. COUNT | Υ | 10c. CITY, TO | OWN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| FRARYLAND BAY | 390m. T | L CE | IRNEY | | | | 1 YES 2 NO |
| 10e. STREET AND NUMBER | | | 101. ZIP | CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 1000 = DOC | 1000 Roa | 0 | 0 | 12211 | | 11 | 0.2 |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. | 100 | 0 | 10074 | | <u> </u> | · 7 · 17 · |
| 1) Never Married 2 Merried | FORCES? 1 YES 2 | NO | If yes, specify | NT OF HISPANIC Cuben, Mexican, | ORIGIN? (Specify Yes Puerto Ricen, etc.) | or No- 14. | RACE — American Indian, Black, White, etc. |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 🗆 YES 2 | NO Specify: | | | Specify: |
| | 1 | | I | | | 1 \ | STIKU |
| 15. DECEDENT'S EDU (Specify only highest grade | | (Give kind of work | done during most of v | working | 16b. KIND OF BU | SINESS/INDUST | TRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ilfe. Do NOT use re- | tired.) | | | | |
| | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | 18. | MOTHER'S NAME | (First, Middle, Malden | Sumame) | |
| Danalo | M. CROMER | 2 | | 0.0 | RA I | (50) | ٠ . |
| 19e. INFORMANT'S NAME (Type/Print) | 1. 6. 41 121 | | DDECC (Ottook and No | 026 | uta Number, City or Tow | Contraction Contraction | 3 |
| 1=0 · · · · / Q | | 190. MAILING AD | DRESS (Street and No | Imber or Hural Hol | uta Number, City or low | m, State, ZIP COC | 76) |
| LHUITA IN | COROS | SAI | 25 15 | HI5 | OV | | |
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29c. LICENSE NUMBER

D

37986

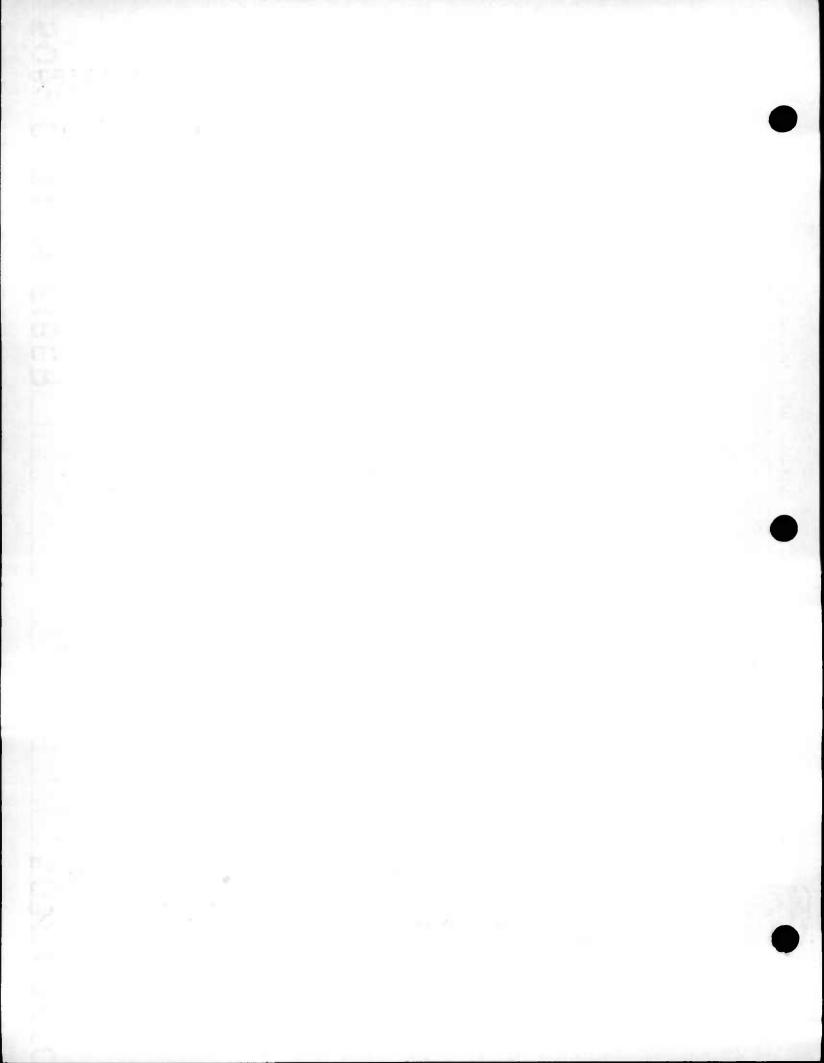
Hd

29d. DATE SIGNED (Month, Day, Year)

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| ATT Y | RECTIC | 1 |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZFT hours after death. Page 6 may be retained by the hospital or attending | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the new within 72 hours after death with the State Dend. of Health and Mental Hydlene prior to burial, cremation, or removal. | sentiments the modern to the solid and the solid solid and the solid solid solid solid solid solid and solid of some |
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| TO T | 日本 | |

| 1. DECEDENT'S NAME (First, Middle, Last) Elsie Curtis | | | | | | | 2. DATE | of DEATH | NY. | JEAN | 3. TIME OF DEATH | |
|--|--|---|------------------|--|-------------|--|-------------|-------------------------------------|-------------------------------------|-----------------------------|--|--|
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. I | est birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTH | | 6. BIRTH | PLACE (State or Foreign | |
| 213-16-5326 | 1 🗆 M 2 🏠 🏋 | 98 YRS. MONTHS DAYS HOURS MIN. (Months Days 199 | | | | 29/18 | 92 | Maryland | | | | |
| 9a. FACILITY NAME (If not institution, give a | | | | 9b. CITY, | TOWN 0 | R LOCATION OF D | | | | NTY OF D | EATH | |
| Summitt Nursin | g Home | | | | | | | | Bal | Ltim | timore | |
| 10a. STATE 10b. COUNTY | 1 | | | Y, TOWN O | | | | | | Т | 10d. INSIDE CITY LIMITS? | |
| MD | | | E | Baltimore | | | | | | X X YES 2 NO | | |
| Westminster Ho | use/524 | N. Cl | | | | | 10g. CIT | | HAT COUNTRY? | | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Vidowed 4 Divorced | 12. WAS DECEDED FORCES? IF YES, GIVE | T EVER IN U.S. I I YES X X (A | NO | | f yes, spe | ENGENT OF HISPA elfy Cuban, Maxic 2 12 140 Speci | an, Puarto | | or No— | 14. RACE Black Specif | - American Indian, White, etc. y: White | |
| 16. DECEDENT'S EDUCATION (Specify only highest grade completed) | | | | USUAL OG | | N it of working | 16 | b. KIND OF BU | SINESS/IN | DUSTRY | | |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | | | se retired.) | | | | | | | | |
| unknow 17. FATHER'S NAME (First, Middle, Lest) | <u>n</u> | uı | <u>ıknov</u> | vn | | | | nknow | | | | |
| Joseph Degenha | m d + | | | | | 16. MOTHER'S N. | | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | LUL | Т. | 19b. MAILING | 3 ADDRESS | (Street a | Mal and Number or Rural | | isenh | | | | |
| Elsie Barnes | | | | Road | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1 Burlal XX Cremation 3 Ram | E OF DISPO | SITION (No. | me of cen | elegy commetons or | | wn, Stata | | | | | | |
| 4 Donation 5 Other (Specify) | OVAI ITOM Stata | Gre | eenmo | ount | Cr | ematory | 7 | e, MD | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSER | lite | | 22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Fune | | | | | neral Home, Inc g Rd/Balto. MD 2 | | | |
| shock, or heert fellure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | M | OR AS A CONS | - | lia | þ | rinda | rel | tion | | | Interval Betwee | |
| Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | | CONSEQUENCE OF): | | | | | | | | | |
| PART II. Other aignificant condition | es contributing to | death but no | t resulting | in the un | derfying | cause given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | RMED? | 24b. | WERE AUTOPSY FINDRIN AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PL | ACE OF DEATH (C | heck only o | one) | | | | |
| EXAMINER? | HOSPITAL: | ☐ ER/Outpatient | 3 DOA | OTHER | | 5 - Residence | 6 🗆 Oth | ner (Specify) | | | | |
| 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation | F INJURY Day, Year) | 26b. TIR | | 28c. INJ WO | | 7 | ESCRIBE HOW | INJURY O | CURED | | | |
| 3 Suicide 6 Could not be determined | 28e. PLACE building | OF INJURY — At , etc. (Specify) | home, farm, | street, fact | lory, offic | | | CATION (Street y or Town, State) | | er or Rural F | loute Number, | |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE | | | | | | | | | | |) and manner as stated | |
| 296. SIGNATURE AND TITLE OF CERTIFIED | 1 Roy | ve) | nI | 5 | | 29c. LICENSE NU | MBER 17/ | 2.0 | 29d. DA | TE SIGNED | (Month, Day, Year) | |
| 30, NAME AND ADDRESS OF PERSON WH | O COMPLETED CAL | JSE OF DEATH (I | TEM 27) (Type | e, Print) | | | | | 2-4- | | 0 | |



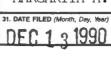
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2... nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

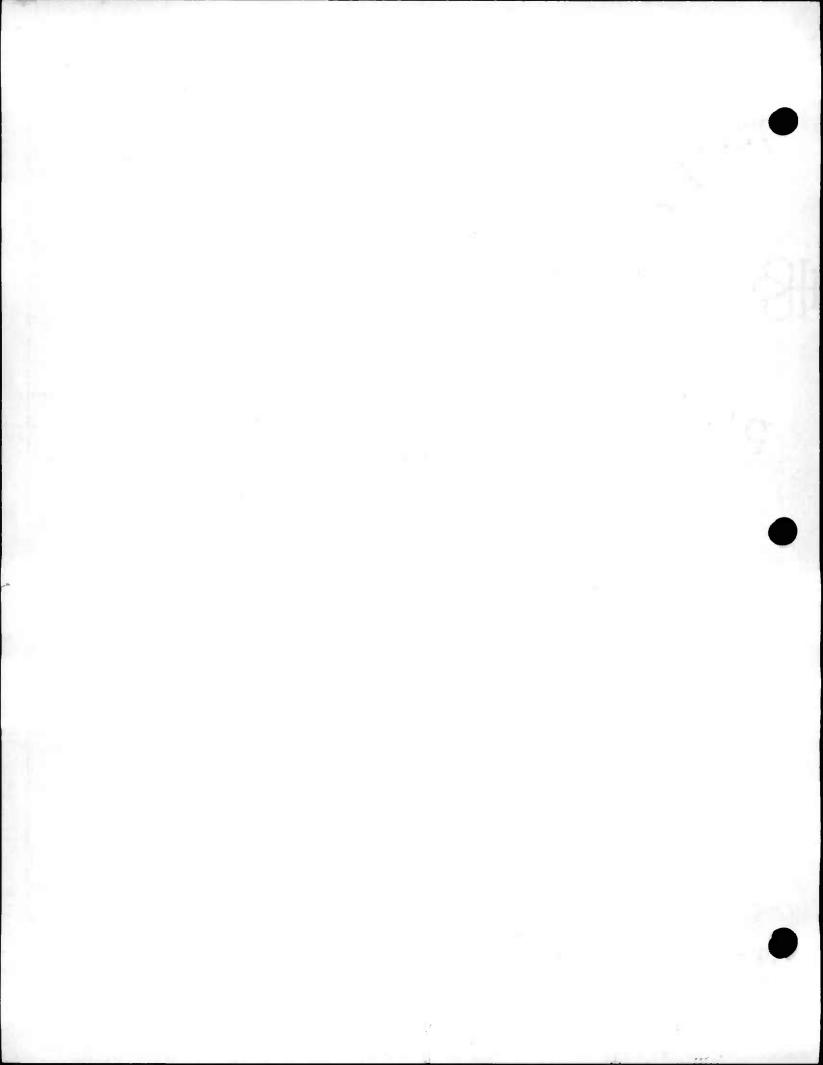
IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS:23,27 per ME

| | G-6/1 1/19/91 Cn FOR 1 STATE | | MARYLAND / | | | | | | MENTA | L HYGIENI | Ε . | | 04100 |
|-------------------|--|-------------------------------|---------------------|--------------|----------------|----------|-----------|-----------|------------|----------------------------------|--------------|-----------------------|--|
| | REGISTRAR | | CE | RTIFI | CATE C | OF D | EAT | TH | | REG. NO. | | | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | _ | | | | | | MONT | E OF DEATH | Y Y | EAR 3. | TIME OF DEATH |
| - 1 | | Doi miles | | | | | | 2-6-90 | | | 2:10PM M | | |
| -1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER 1 YE | | OURS | 24 HRS. | 7. DATE | of BIRTH | 6. | ENTU | ACE (State or Foreign |
| | 223-13-8462 | 1 🗌 M 2 💢 F | 30 | YRS. | | | | | FEB | . 20,15 | 760 K | EIVIU | CKI |
| | 9e. FACILITY NAME (If not institution, give a | street and number) | | | 96. CITY, TO | WN DR | LOCATIO | ON OF DE | HTA | | 9c. CDUNTY | OF OEAT | тн |
| DIRECTOR | Patuxant River Hospital Patuxant St. Mar | | | | | | | | | | ary' | s County | |
| 5 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY. TOWN OR LOCATION | | | | | | | | | | 14 | Dd. INSIDE CITY | |
| E | | • | | | | | | | | | | | LIMITS? |
| | MD. ST. N | MARY'S CO | YII'IUC | LEX | KINGTO | ~ | | | | | | | YES 2 NO |
| MA I | | | | | | | IP CODE | | | | | | AI COUNTRY? |
| FUNERAL | RT. 1, BOX 317-E 20653 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC OR | | | | | | | | | | S.A. | | |
| 5 | 11. MARITAL STATUS 1 Never Married 2 X Married | FDRCES? | 1 YES 2 X | MED | | | | | | IN? (Specify Yee Rican, etc.) | or No.— 14 | Black, V | - Americen Indien, White, etc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE | WAR OR DATES | | 1 🗆 | YES 2 | Хио | Specify | / : | | Ι, | Specify: WHIT | TC . |
| | 15. DECEDENT'S EDU | ICATION | 16a, DE | CEDENT'S L | ISUAL OCCU | PATION | | - | 16 | b. KINO OF BUS | | | |
| EI | (Specify only highest grade | completed) | (G | | ork done durin | | of workin | ng | 1 | | | 2000 | |
| 7 1 | Elementary/Secondary (0-12) | College (1-4 or 5 4 YEARS | | IOUSEV | रंग कार | | | | | LIOME | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 4 ILANS | | COSEV | ATEC | 1 | s. MOTI | HER'S NA | ME (First. | HOME Middle, Maiden | Sumeme) | - | |
| | HERBERT DEAN TOWN | | | - 1 | | | - 1 | 3-111 | | | | | |
| B | 19a. INFORMANT'S NAME (Type/Print) | ML-C-Y | 19 | MAILING | ADDRESS (St | met end | | | | S MYERS | | ode) | |
| 2 | | D - A DAMEST | | | | | | | | TON PAR | | | 653 |
| | THOMAS MCCLELLAN 200, METHOD OF DISPOSITION | DEARMEY | 20h PLACE | | TION (Name | | | _ | | | CATION - CIT | | |
| | 1 Donation 5 Other (Specify) | noval from State | _ LEE C | ece) | | | -,, | | | | NTON, | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE / | _ <u> 11155 C</u> | ICLIANT | 22 NAB | AE AND | ADDRE | SS DF FA | CILITY | | | | |
| | 22. NAME AND ADDRESS OF FACILITY MATTINGLEY—GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650 | | | | | | | | | | | • | |
| | Michael 7 | X/ard | mer | | P.C |). E | 3OX | 270, | , LE | ONARDIO | M, NW | D. 2 | 0650 |
| | 23. PART (. Enter the diseases, or | | | | ot enter the | mode | of dy | ing, suc | h as ca | rdiac or respi | retory arres | it, | Approximate interval Between |
| | | | | | | | | | | | | Onset and Death | |
| - 1 | disease or condition resulting in death) | . HYPERT | ROPHIC C | ARDIC | MYOPA | THY | | | | | | | |
| | | | O (OR AS A CONSE | | | | | | | | | | |
| Z | | b | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO | O (OR AS A CONSE | QUENCE OF |): | | | | | | | | |
| 5 | CAUSE (Disease or Injury | C | | | | | | | | | | | <u> </u> |
| H | that initiated events resulting in death) LAST | DUE TO | O (OR AS A CONSE | QUENCE OF |): | | | | | | | | İ |
| # | Total and an addition and a | d | | | | | | | | | | | - |
| L | PART II. Other aignificant condition | na contributing t | o death but not | resulting is | n the unde | riying (| cause | given in | Part i. | 24a. WAS AN | AUTOPSY | 24b. V | VERE AUTOPSY FINDINGS |
| - | | | | | | | | | | XXXVES 2 | RMEO? | | WAILABLE PRIDE TO COMPLETION OF CAUSE |
| | | | | | | | | | | VIOTAES V | ı 🗆 NO | | OF DEATH? |
| Σ | | | | | | | | | | | | 122 | 1 123 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | Т | | | | 26. PL A | CE OF 0 | DEATH (C/ | neck only | one) | | | |
| PHYSICIAN: MEDICA | EXAMINER? | HOSPITAL: | ER/Outpatient | □ DOA | OTHER: | | | 000 | | | | | |
| ξĮ | 27. MANNER OF DEATH | 26e. DATE C | | 26b. TIMI | 4 Nursing | c. INJUF | | esidence | | EŞCRIBE HDW | INJURY OCCU | RED | |
| | 1 Natural 5 Pending | | Day, Year) | INJ | JRY | WOR | C7 | ND. | | | | | |
| B | 2 Accident Investigation | 26e, PLACE | OF INJURY — At he | ome, farm, s | | | | | 26f. LC | OCATION (Street | and Number o | r Rumi Ani | ute Number |
| | 3 Suicide 6 Could not be 4 Homicide determined | building | g, atc. (Specify) | , | , | , 000 | | | Ci | ty or Town, State |) | | |
| <u>=</u> | 29e. CERTIFIER | | | | | | | | | | | | |
| M N | (Check only CERTIFYING PHY | SICIAN: To the best | | | | | | | | | | | ea construction |
| COMPLETED | MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and m | | | | | | | | | | | end menner se stated. | |
| BE | 290 FIGHATURE AND TITLE OF CERTIFI | CLA | | | | - 13 | 29c. LIC | OCM | | | 29d. DATE | 2-7- | Month, Day, Year) |
| 10 | munite like | ypell | | | | | | ~1.11 | _ | | 1 | - ' | |
| - | 30. NAME AND ADDRESS OF PERSON W MARGARITA A. KO | HO COMPLETEO CA RFT T . MO | USE OF DEATH (ITE | M 27) (Type, | Print) | 1 De | nn | Str | -p-t | Baltimo | Oro Mr | 210 | 01 |
| - 2 | | | | | ala ala | J. C | A 55.4 | 4 - 6 - 6 | | Service Control (19 | | | |
| | 31. DATE FILED (Month, Day, Year) | 20 8 | RAR'S SIGNATURE | | | | | | | | | | |
| 1 | THE !! 13 1990 3 | Fisher Davids | on-lander | | | | | | | | | | |
| | | - | | | | | | | | | | | DHMH-16 Rev 1/89 |



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| | 24 HOURS |
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| 13 | executed |
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| 0. 80 | certificate |
| σ, | death |
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| | that |
| 300 | requires |
| - | AR! |
| Z | The |
| ISION OF VITAL RECORDS, P.O. BOX 13 | ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after |
| ISION | ATTENDING |

| L | FOR STATE REGISTRAR | STATE OF | MARYLAND / | | | | EALTH AND N | MENTAL | HYGIEN REG. NO. | E 90 |)-3 | 4159 | |
|---|---|--|--|-------------|-------------|----------|--|-------------|----------------------------------|--|-----------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle | Janet Janetar | Ann DePa: nn | ALO | | | of DEATH | Ď, 19 | | :14 PM M | | | |
| | 4. SOCIAL SECURITY NUMBER 212-50-3314 99. FACILITY NAME (If not institution | 5. SEX 1 M 2 F | 6. AGE (In yrs. les | | | AYS | IF UNDER 24 HRS. HOURS MIN. R LOCATION OF DE | (Month | OF BIRTH , Day, Year) 4-47 | 8. | BIRTHPLA Country) | CE (State or Foreign | |
| HOT. | Franklin Squa | | 1 | | Ros | svi | lle | | | County | | | |
| DIRECTOR | 10a. STATE 10b. (| 10b. COUNTY 10c. CITY, TOWN OR LOCATION Baltimore Essex | | | | | | | | | | I. INSIDE CITY LIMITS? YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 1534 Hopewell | | | | | ZIP CODE | | | 109. CITIZE | | COUNTRY? | | |
| B | 11. MARITAL STATUS 1 Never Merried 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | | | Пy | es, spe | NDENT OF HISPAN city Cuben, Mexical 2 NO Specify | n, Puerto I | | | 4. RACE — Black, W Specify: | American Indian, hite, atc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | | | | |
| OMP | 12 Sales Representative Heching 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden | | | | | | | | | Surname) | | | |
| H | Nicholas Anthony DePalo, Sr. Gercrude Marie Wi. | | | | | | | | | | code) | | |
| ٤ | Nicholas DePalo 6406 Fairdel Avenue Baltimore, MD. | | | | | | | | | MD. | 21206 | | |
| | 11 Burlel 2 Cremetion 3 Removal from State other place) 4 Donation 5 Other (Specify) Gardens of Faith Comptons | | | | | | | | | 20c. LOCATION — City or Town, State Baltimore, MD. | | | |
| | 21. SIGNATURE OF FUNERAL SERV | ice Licensee | Fi | | | | o address of Fa Belair R | | | Fune: | | ome, Inc. 21206 | |
| | 23. PART Enter the dispesse whock, or heart for limmEDIATE CAUSE (Finel disease or condition resulting in deeth) | a. Mul | tiple Sec | ond D |)egree | е Ві | | h ee cere | dec or reep | iretory erre | et, | Approximete Interval Between Onset end Deeth | |
| CERTIFICATION | Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente recuiting in death) LAST | a Arr | tiple Org TO (OR AS A CONSE NYTHMIA TO (OR AS A CONSE | OUENCE OF | F): | | | | | | | | |
| PHYSICIAN: MEDICAL C | PART II. Other significent co | nditione contributing | to deeth but not | reaulting (| in the unde | erlying | ; ceuse given in | Part I. | 24a. WAS AMPERFO | RMED? | AM CC OF | REAUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO | |
| ICIAN | 25. WAS CASE REFERRED TO MED EXAMINER? | HOSPITAL | | | OTHER: | 26. PL | ACE OF DEATH (Ch | eck only o | ne) | | | | |
| PHYS | 1 YES 2 NO 27. MANNER OF DEATH | 28a. DATE | 2 ER/Oulpatient OF INJURY h, Day, Year) | 286. TIM | | 8c. INJ | URY AT RK? | | SCRIBE HOW | INJURY OCCU | JRED | | |
| 2 Accident Investigation 25s. PLACE OF INJURY — At home, farm, street, factory, office. | | | | | | | | | ATION (Street or Town, State | | or Rural Rout | te Number, | |
| COMPLETED | CONSON CINY | G PHYSICIAN: To the bear | | | | | | | | | | nd menner as stated. | |
| TO BE C | 296. SIGNATURE AND TITLE OF C | ETT N | 10 | | | | 29c. LICENSE NU | MBER | N/ A | | SIGNED (M | onth, Day, Year) | |
| | Carolyn Hai | mmett, MD | 9000 | Facai | nklin | Sq | uare Dri | ve | Baltin | ore, | MD | 21237 | |
| | Carolyn Hammett, MD 9000 Faranklin Square Drive Baltimore, MD 21237 31. DATE FILED (MONTH OF THE PROPERTY OF | | | | | | | | | | | | |

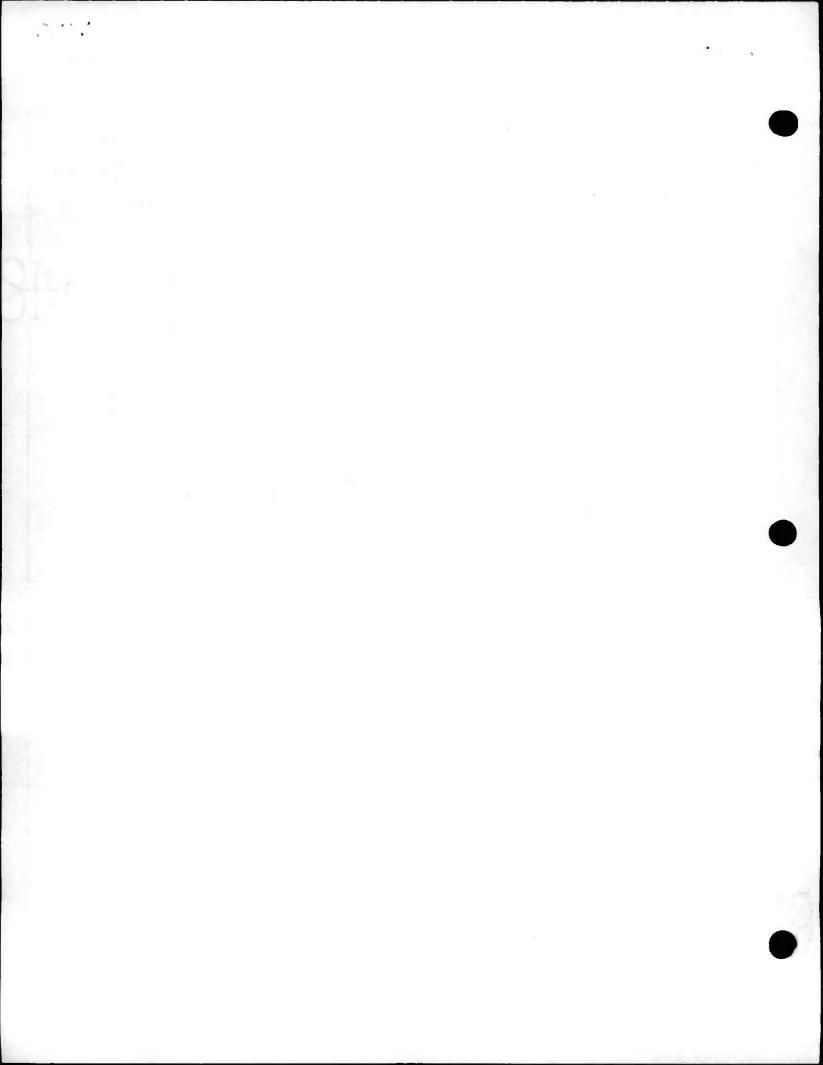
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TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 | - STATE REGISTRAR | OTHE OF MARKET | CERTIF | ICATE C | F DEATH | REG. NO. | | | | | |
|---------------|--|---------------------------------|------------------------------|----------------------------------|---|------------------------------|---------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | NY YEAR | 3. TIME OF DEATH | | | |
| | CATHERINE L | DORSEY | | | | 12 07 | | 0 9:45AM M | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. last birthday) | IF UNDER 1 YE | | 7. DATE OF BIRTH | 8. BIF | TTHPLACE (State or Foreign | | | |
| 1 | 578-26-2364 | 1 D M 2 🔀 F 7 | 5 YRS. | MONTHS DAT | TE HOURS MIN. | (Month, Day, Year) 6/1/15 | | ach D.C | | | |
| | 9e. FACILITY NAME (If not institution, give a | street end number) | | 9b. CITY, TOV | VH OR LOCATION OF D | EATH | 9c. COUNTY O | | | | |
| DIRECTOR | PRINCE GEORGE'S | HOSPITAL CEN | TER | CHE | /ERLY | | GEORGE 'S | | | | |
| Ĭ | 10a. STATE 10b. COUNT | Y | 10c. CIT | Y, TOWN OR LO | DCATION | | | 10d. INSIDE CITY LIMITS? | | | |
| ā | Md. P | .G. | Fai | rmoun | t Height | S | | TXXXES 2 NO | | | |
| FUNERAL | 10a. STREET AND NUMBER 5516 Add | ison Rd. | | | 101. ZIP CODE 20743 | | | F WHAT COUNTRY? | | | |
| Ž | 11. MARITAL STATUS | 12 WAS DECEDENT EVED | IN U.S. ARMED | | DECENDENT OF HISPA | NIC ORIGIN? (Specify Yes | or No- 14. R | ACE — American Indian, lack, White, atc. | | | |
| BY FI | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | DATES NO | | s, specify Cuben, Mexico YES ZONO Specif | | S | Black Black | | | |
| | 15. DECEDENT'S EDU | JCATION | 16a. DECEDENT'S | USUAL OCCU | PATION | 16b. KIND OF BU | | | | | |
| <u> </u> | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done during se retired.) | g most of working | | | | | | |
| ᆲ | 11th | | Homem | aker | | Own 1 | Home | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Maiden | | | | | |
| | Mark | E. Martin | | | Mary | Savoy | | | | | |
| B | 19e. INFORMANT'S NAME (Type/Print) | D. Harein | 19b. MAILING | ADDRESS (St | | Route Number, City or Tow | n, State, Zip Code, | | | | |
| 일 | Ralph E. Dor | CAV | | | # 10 abo | | | | | | |
| | 20a. METHOD OF DISPOSITION | 20 | Ob. PLACE OF DISPO | | of cemetery, cremetory or | | CATION — City o | r Town, State | | | |
| | 4 □ Donation 5 □ Other (Specify) | nound from State | other place) | | | 14/90 | dover | . bm | | | |
| ı | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | armony | 22. NAN | IE AND ADDRESS OF F | 14/90 Land | acvery. | | | | |
| 1 | Larry. | N. (3/11 | 20 | Н. | S.Washin | gton & Soughs Ave | ons, In | c. | | | |
| | 23. PART i. Enter the diseases, or | | | | | | | Approximate interval Between | | | |
| | ahock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF) CARDINC Arrest b. CARDINC Arrest | | | | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST b. CALDIAC Arrest DUE TO (OR AS A CONSEQUENCE OF): C. CITCHES VISCUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | |
| DICAL | PART ii. Other eignificant condition | ena contributing to death | but not resulting | in the under | rlying cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | COP | | | | | 1 - YES | 2 100 | OF DEATH? 1 YES 2 NO | | | |
| ÷ | | | | | | | | | | | |
| PHYSICIAN: ME | 25. WAS CASE REFERRED TO MEDICAL | | | | 28. PLACE OF DEATH (C | check only one) | | | | | |
| Sic | 1 YES 2 NO | HOSPITAL: | utpatient 3 DOA | OTHER: | Home 5 - Residence | 8 Other (Specify) | | | | | |
| È | 27. MANNER OF DEATH | 26a. DATE OF INJUR | | ME OF 28 | c. INJURY AT | 28d. DESCRIBE HOW | INJURY OCCURE | D | | | |
| | Natural 5 Pending | (Month, Day, Year | ' I ''' | M 1 | WORK? | | | | | | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e, PLACE OF INJU | ural Route Number, | | | | | | | | |
| COMPLETED | (Uneck only | SICIAN: To the best of my kn | owledge, death occur | red at the time | , date and place, end de | ue to the cause(s) end m. | anner as stated. | | | | |
| S | one) 2 MEDICAL EXAMIP | NER: On the basis of examina | tion and/or investigat | lon, in my opin | ion, death occured at 1 | ne time, data and piece, a | and due to the car | use(a) and manner as stated. | | | |
| | 296. SIGNATURE AND TITLE OF CERTIFI | ER | | | 29c. LICENSE N | UMBER | | INED (Month, Day, Year) | | | |
| BE | oochep | | | | D34 | 122 | 1 /2 | -7-80 | | | |
| | A. NAME AND ADDRESS OF PERSON W Vicken Poochi | rho completed cause of | 5632 Ar | napol | | | | | | | |
| | | 32. BEGISTRAR'S SI | | | | | , | | | | |
| | DEC 1 3 1990 | Julia Davidson-A | andell | | | | | | | | |





DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

ATENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician.

ECIDR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should at each with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | MENT OF H | | | GIENE G. NO. | | | | |
|-----------------|---|--|--|---------------------------------|---------------------------|------------------------------|----------------------------------|----------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 797 | | | 2. DATE OF OR | | | B. TIME OF DEATH | | |
| | WILLIAM Edw | 224 | DORSEY | | | MONTH | 2 011 | 90 | 11:30P M | | |
| | | | n yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIF | TH | 8. BIRTHP | LACE (State or Foreign | | |
| | 216 10 2270 1 | M 2 □ F | MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) | | | | | | | | |
| | 216-10-3379 19. FACILITY NAME (If not institution, give street | 1 1 82 1 108/09/1908 Mai | | | | | | | | | |
| œ | | | | | | | | | | | |
| DIRECTOR | UNION MEMORIA | MEMORIAL HOSPITAL BALTIMORE CITY | | | | | | | | | |
| 입 | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | 1 | IOd. INSIDE CITY | | |
| ≝۱ | Maryland | | | -1 | | | | | LIMITS? | | |
| | 10e. STREET AND NUMBER | | | altimo | ZIP CODE | | 10n, CIT | | IAT COUNTRY? | | |
| & | 1022 Day 3 d Holl | 7 | | | | | | | | | |
| FUNERAL | 1922 Druid Holl | A VEHUE | LUG ADMED | 40 3440 050 | 21217 ENDENT OF HISPAN | IC ORIOINS (C- | U. | | A . American Indian. | | |
| 립 | 1 Never Married 2 X Merried | FORCES? 1 TYES | 2 00 | If yes, sp | ecity Cuben, Maxica | n, Puarto Rican, | | Black, | White, atc. | | |
| ă | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ITES | 1 YES | 2 NO Specify | | | Specify | | | |
| | 15. OECEDENT'S EDUCATE | ION | 16a. DECEDENT'S U | SUAL OCCUPATION | N | 16b, KIND | OF BUSINESS/INC | DUSTRY | Black | | |
| ËI | (Specify only highest grade com Elementary/Secondary (0-12) C | | (Give kind of we | ork done during mo retired.) | st of working | | | | | | |
| ا ٦ | High school | College (1-4 or 5+) | Weld | or | | Po+1 | hlehem | Ctoo | 1 Cown | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | мета | ET | 16. MOTHER'S NA | | | Stee | el Corp. | | |
| | | 017 | | | | | | | | | |
| B | William E. Dors 190. INFORMANT'S NAME (Type/Print) | EY | 19h MAH ING | Inopese /Strant | ROSE | Brown | v or Town Chata 74 | n Codel | | | |
| 유 | Dona Dorsey | | | | | | | | WD 21217 | | |
| | 200, METHOD OF DISPOSITION | 205 | PLACE OF DISPOSI | | Hill A | | 20c. LOCATION — | | | | |
| | 1 🔀 Burial 2 🗆 Cremation 3 🗎 Removal | from State | other place) | | | | | | | | |
| | 4 Donation 5 Other (Specify) | QEE. | <u>Arbutus</u> | | | | Baltir | nore | Co., MD | | |
| | | 2 2 | | 250 | 1 CTTTO | Nut | ter Fur | neral | L Homes | | |
| | +lewest E | - hutt | er | | 1 Gwynn timore, | | | | | | |
| | 23. PART i. Enter the diseases, or comehock, or heart fellure. List | | | ot enter the mo | de of dying, auc | h ae cardiac d | or reapiratory er | reet, | Approximete interval Between | | |
| - { | IMMEDIATE CAUSE (Finei | | | | | | | | Onset end Death | | |
| | disease or condition resulting in death) | PN | manie | - | | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE, OF | : | | | | | | | |
| z | | Rena | al tail | me | | | | | | | |
| 읽 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | : | | | | | | | |
| <u>ა</u> | CAUSE (Disease or injury | | | | | | | | | | |
| 1 | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF | : | | | | | i | | |
| CERTIFICATION | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other aignificant conditione c | ontributing to death b | ut not resulting in | the underlyin | g cause given in | | WAS AN AUTOPSY | | WERE AUTOPSY FINDINGS | | |
| CAL | | | | 100 | | | PERFORMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | | | | | | — 'L | YES 2 NO | - 1 | OF DEATH? | | |
| Σ | | | | | | | | | 1 TYES 2 NO | | |
| A S | TE WAS CASE PETERBER TO LICENSE | | | | AGE OF DESTRUCTION | | | | | | |
| PHYSICIAN: MEDI | | IOSPITAL: | -3-2 | OTHER: | LACE OF DEATH (Ch | eck only one) | | | | | |
| ×S | | Inpatient 2 ER/Outp | | | ne 5 🗆 Reeldence | | | | | | |
| 표 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28s. DATE OF INJURY (Month, Day, Year) | 26b. TIME | JRY W | JURY AT DRK? | 28d. DESCRIB | E HOW INJURY O | CURED | | | |
| B | 2 Accident Investigation | | | | YES 2 NO | | | | | | |
| - 1 | 3 Suicide 6 Could not be | 28e. PLACE OF INJURY building, etc. (Spec | — At home, farm, s clfy) | reet, factory, offi | :0 | 281. LOCATION City or Tox | l (Street and Numbe m, Stale) | er or Rural Ro | oute Number, | | |
| COMPLETED | | | | | | | | | | | |
| 귈 | 29a. CERTIFIER 1 CERTIFYING PHYSICIA | N: To the best of my know | ledge, death occurre | d at the time, dat | end ptaca, end due | to the cause(e) | and manner ae sta | ated, | | | |
| 0 | one) 2 MEDICAL EXAMINER: (| On the basie of examinatio | n and/or/minution | n, in my opinion, | feath occured at the | time, date and | place, end due to t | the ceuse(s) | and manner as stated. | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | 111 () | 1100 | -11) | 29c. LICENSE NUI | WBER | 29d. DA | TE SIGNED | (Month, Day, Year) | | |
| BE | Paris M | Illes of | KANIVI | rella- | 9370 | 76 | • | 12 | 111/90 | | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF OF | ATH (ITEM 27) (Type, | Print) | | 2 ~ | | . ~ | 1110 | | |
| | Parrice 1 | 1.ller_ | | | | | | | | | |
| | | 32. REGISTRAR'S SIGN | ATURE | | | | | | | | |
| | DFC 13 1990 | Sha Davidson | | | | | | | | | |

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make the second

AND THE STREET

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

JOHN

Н.

31. DATE FILED (Month, Day, Year)
DEC 1 3 1990

NADING

CDR,

MC,

32. REGISTRAR'S SIGNATURE

2

| | | | | | | | | | | | (| 9.0 | 34162 |
|---|---|---------------------------|---------------------|-------------------------|--------------|----------------|---------------|-------------|---------------|---------------------------|-------------------|-----------------|---|
| | 1 - FOR STATE REGISTRAR | STATE OF M | IARYLAND / CE | DEPAR | TMENT | OF H | EALTH DEAT | AND I | MENTAL | HYGIEN REG. NO | | | |
| i | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | OF DEATH | | YEAR | 3. TIME OF DEATH |
| 1 | | CHR | ISTIAN 1 | ו דקוות | ISH | | | | NOV | 29 1 | | TEAH | 1:36 A M |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | PLACE (State or Foreign | | | |
| | NT / A | 1 🖳 M 2 🗆 F | T. Olivernous | YRS. | MONTHS | DAYS | HOURS | MIN. | | , Day, Year) | v) | | |
| | N/A 9a. FACILITY NAME (If not institution, give s | | | | an CITY | TOWN O | R LOCATIO | ON OF DE | | 28 1 | | MA NTY OF DE | RYLAND |
| œ | | | | | SECULT, | | | | AIR | | 90.000 | NIT OF DE | EAIN |
| 0 | NATIONAL NAVAL | MEDICAL | CENTER | | | BET | THEST |)A | | | MON | NTGOM | IERY |
| EC | 10a. STATE 10b. COUNT | | | 10c. CIT | Y, TOWN O | R LOCAT | ION | | | | | | 10d. INSIDE CITY |
| DIRECTOR | VIRGINIA PRI | ΔΜ | | TRIANGLE | | | | | | | | LIMITS? | |
| | 10e, STREET AND NUMBER | NOL WILLIAM | ATT . | | | - | ZIP CODI | | | | 10a, CIT | IZEN OF W | /HAT COUNTRY? |
| FUNERAL | 18157 KILMER | TANE ADD | 20% | | | , | 22172 | 2 | | 1 | | | |
| N | 10137 KILITEK | 12. WAS DECEDEN | | MED | 12.9 | MAC DEC | | | | ? (Specify Yea | | - | STATES - American Indian, |
| | 1 Never Married 2 Married | YES 2 TH | NO | | f yes, spe | cify Cuba | n, Mexica | n, Puarto F | | 101110 | Black | , Whita, atc. | |
| If YES, GIVE WAR OR DATES 1 YES \$\(\) NO Specify: | | | | | | | γ: | | | Specif | " BLACK | | |
| | | | | | | | | | | | | | |
| | (Specify only highest grade | e completed) | (G | ive kind of Do NOT u | work done o | during mos | st of working | ng | | | | | |
| 7 | Elementary/Secondary (0-12) N/A | College (1-4 or 5 + | ' | | N/A | | | | ı | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | N/A | | 18. MOT | HER'S NA | ME (First A | liddle, Maiden | Sumama) | _ | |
| ŭ | JEROME DALE DI | поп поп | | | | | 192 | | | ALESH | | DLITC | ידי |
| BE | 19a. INFORMANT'S NAME (Type/Print) | DELOSII | 19/ | h MAII INC | ADDRESS | Street a | nd Number | | | ALESTI er, City or Tow | | | ,K |
| 2 | | 17 | | | | | | | | | | | 00170 |
| | JEROME D. DUPLUSI | а | 20b. PLACE | | | | | | PT 20 | | LANGI CATION — | | A 22172 |
| | 1 🛱 Buriel 2 □ Cremetion 3 □ Ren | noval from State | other pl | lece) | | | | | | | | | |
| | 4 Donation 5 Other (Specify) 21, SIGNATURE OF FUNERAL SERVICE LI | CENSEE | Quan | tico | Natio | nal (| Jeme | etery | CHITY | Tri | angle | . Vir | ginia |
| | Of as | | | | | | | | | Home | | | |
| | HAMILK 1 | wik | Q(| | | | | | | e City | | 2219 | 3 |
| | 23. PART 1. Enter the diseases, or shock, or heart failure. | complications that | t caused the de | eath. Do | not enter | the mo | de of dy | ing, suc | h as card | liac or reap | iratory ar | rest, | Approximate interval Batwaan |
| | IMMEDIATE CAUSE (Final | List only one out | ioo on odon mie | | | | | | | | | | Onset and Death |
| | disease or condition reaulting in death) | EXT | REME PRI | EMATI | JRITY | • | | | | | | | 1 |
| ĺ | roughing in double | DUE TO | (OR AS A CONSE | QUENCE C | F): | | | | | | | | |
| z | | b | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditiona, if any, leading to immediate | DUE TO | (OR AS A CONSE | QUENCE C | NF): | | | | | | | | |
| 8 | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | | | | |
| 띹 | that initiated eventa | DUE TO | (OR AS A CONSE | QUENCE C | F): | | | | | | | | - |
| ᇤ | resulting in death) LAST | d | | | | | | | | | | | |
| - 1 | PART ii. Other algnificant condition | ns contributing to | death but not i | resulting | in the un | dertvino | cause | given in | Part I. | 24a. WAS AN | AUTOPSY | 24b | . WERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | , | , | | | PERFO | RMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| اق | | | | | | | | | - 1 | 1X YES | 2 🗌 NO | - 1 | OF DEATH? |
| | | | | | | | | | | | | | 1 X YES 2 NO |
| z | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | | | | | | | | | | | | | |
| YSI | 1 TYES 2X NO | 1. Inpatient 2 | | | 4 🗆 Nun | sing Hom | | esidence | 8 🗆 Othe | r (Specify) | | | |
| 표 | 27. MANNER OF DEATH 1 Y Natural 5 Pending | 28a. DATE OF (Month, D | | 28b. TII | JURY | 28c. INJ WO | URY AT | | 26d. DES | CRIBE HOW | INJURY OC | CURED | |
| Æ | 2 Accident Investigation | | | | | | | | | | | | |
| Suicide a Could not be a Could not be | | | | | | | | | Route Number, | | | | |
| | 4 Homicide determined | | | | | | | | <u> </u> | | | | |
| COMPLET | (Stroom Striy 11 | SICIAN: To the best of | my knowledge, de | eath occur | red at the t | time, date | and place | , and due | to the car | use(a) and me | nner as sta | nted. | |
| 0 | one) 2 _ MEDICAL EXAMIN | ER: On the basis of a | xamination and/or | investigati | ion, in my o | opinion, d | leath occu | red at the | time, date | and place, a | nd dua to t | the cause(s | a) and menner as stated. |
| | 296, SIGNATURE AND TITLE OF CERTIFIE | in // r | | | | | 29c. LfC | ENSE NU | MBER | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| BE | Way 7/1/ | . 1 | MO |) | | | | | | | D 1 | Var | 30 Kom |

CAUSE OF DEATH (ITEM 27) (Type, Print)

DHMH-16 Rev 1/89

29d. DATE SIGNED (Month, Day, Year)

Nov30 199

CENTER

NATIONAL NAVAL MEDICAL

BETHESDA, MD 20889-5000

3. TIME OF CEATH

YEAR

2. DATE OF DEATH DAY

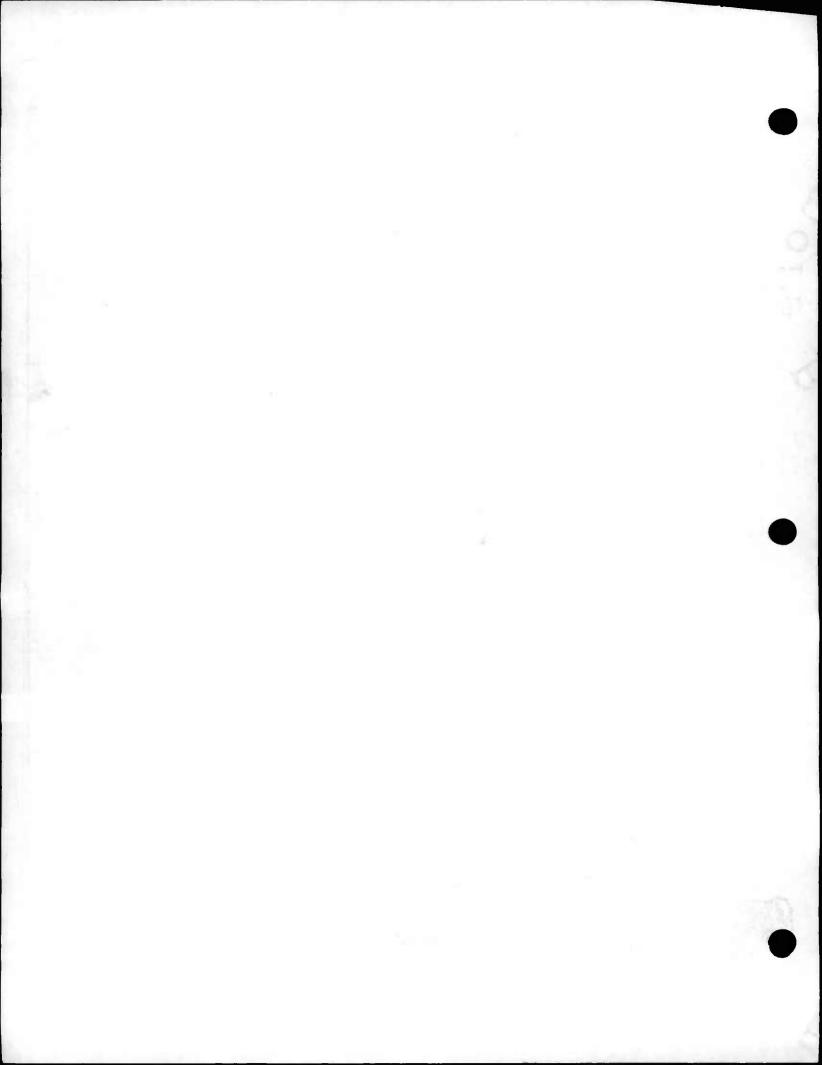
REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

BOX 13146. RECORDS, P.O. DIVISION OF VITAL

Τ. 90 12 Alexis Dutton R 2:50 P 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. last birthday) 6. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR JF UNDER 24 HRS. DAYS 07 HOURS 1 - M 2 - E YRS. N/A 04-26-90 Pages 1, 2, 3 should 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Union Memorial Hospital Baltimore 10a. STATE 10b. COUNTY 10c CITY TOWN OR LOCATION 10d. INSIDE CITY MD BALTIMORE, CITY 1 X YES 2 NO Dermit. FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE use as the burial-transit 5612 LOTHIAN RD. 1st FLOOR 21212 USA 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-if yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 ND 1 Never Merried 2 Married 1 YES 2 NO Specify: Specify: BY 3 Widowed 4 Divorced BLACK ETED 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only higher filled in by the funeral director, page 5 should be detached for on, or removal. Elementary/Secondary (0-12) College (1-4 or 5+) CHILD COMPLI CHIID 17, FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) GREGORY R. DUTTON AMANDA FOSTER Sr. notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 AMANDA FOSTER 3418 MURY AVE. -BALTIMORE, MD. 21214 Pe 20a. METHOD OF DISPOSITION
1 X Murlet 2 ☐ Cremetion 3 ☐ Removat from State 20c. LOCATION - City or Town, State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or must GARRISON FOREST VET. CEM OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND AODRESS OF FACILITY examiner 4-1 ar WM.C, MARCH F.H, 1101 E, NORTH AVE. medical 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, auch as cerdiec or reapiretory arrest, abock, or haert fellure. List only one ceuse on each line. Interval Between cremation, or Onset and Death IMMEDIATE CAUSE (Finel the disease or condition resulting in death) Sudden Infant Death Syndrome completely event, OUE TO (OR AS A CONSEQUENCE OF): in and com to burial, e traumatic NO Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING signed by the attending physician Health and Mental Hyglene prior to CERTIFICAT CAUSE (Disease or Injury other DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST 6 PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE shows any YES 2 NO OF DEATH? 1 YES 2 NO t. of h has by Dept. PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OR ATTENDING PHYSICIAN: The After this certificate hadeath with the State D marked, or item 2 OTHER: XX YES 2 NO 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA 4 🗆 N ng Home 5 - Residence 8 - Other (Specily) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 X Natural 5 Pending M 1 YES 2 NO After 1 BY Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is I 8 Could not be determined COMPLETED DIRECTOR: 4 Homicide TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT De filed within 72 hours a IMPORTANT: If Item 2 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(a) and manner as stated. 📈 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. D TITLE OF CERTIFIE 29b. SIGNATURE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE OCME 12-9-90 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ann M. Dixon, M.D. 111 Penn Street, Balto., Md. 31. DATE FILED (Month, Day, Joan) - -32. REGISTRAR'S SIGNATURE Lulia Davidson Bondatt 1990 **DHMH-18 Rev 1/89**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH



BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

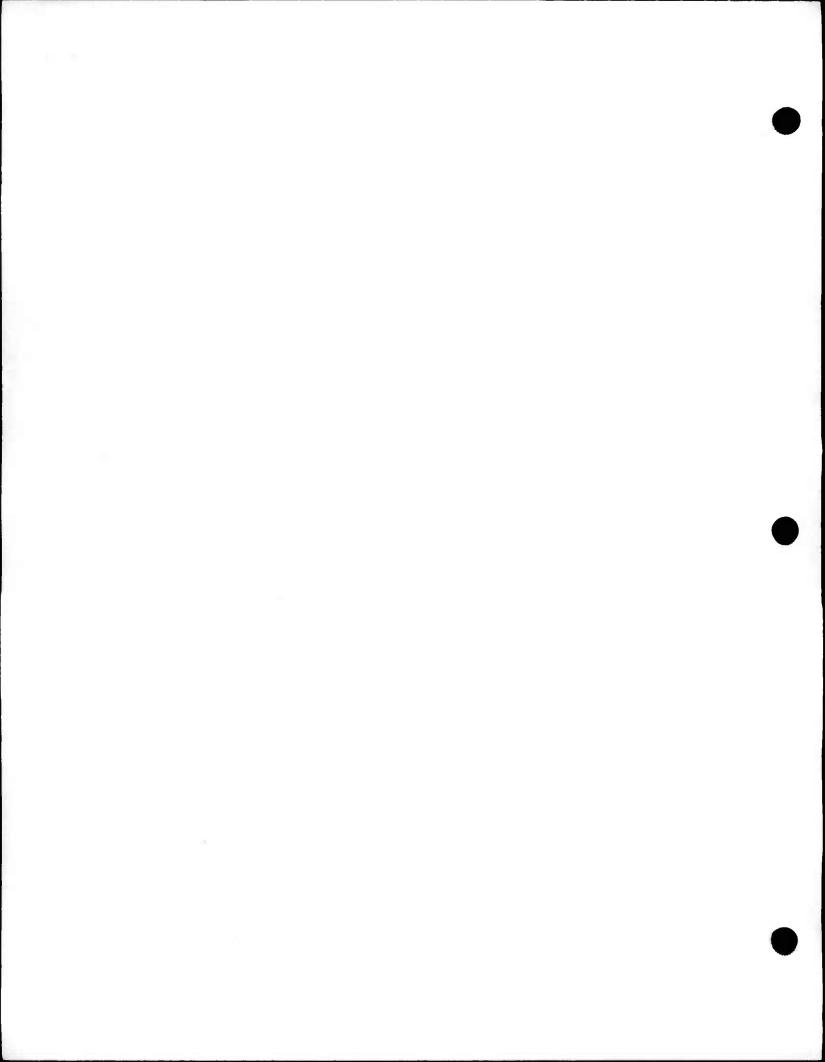
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mouns after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burnil-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31. DATE FILED (Month, Day, Year)

DEC 13 199

32. REGISTRAR'S SIGNATURE

| | 12 10 00, 51 | | | | | | | 90 | 34164 |
|---------------------|---|---|---|--|---|---|---------------------------------------|---------------------------------------|---|
| | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPAR | RTMENT OF I | HEALTH AND I | MENTAL HYGI REG. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) Melvin Evans | Melvin G. E | vans | - | | 2. DATE OF OEAT MONTH | н рау 12- | YEAR | 1:55A M |
| | 015 05 0017 | 5. SEX 6. AGE (In | yrs. leat birthday) YRS, | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea 8/11/ | | 8. BIRTHPLA Country) | CE (State or Foreign |
| OR | 3031 Gwynns Fa | | | 96. CITY, TOWN Balti | MOre | ATH | 9c. COU | NTY OF DEATH | |
| ECT | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c, CI | TY, TOWN OR LOCA | TION | | | 104 | . INSIDE CITY |
| AE . | Md. | | | Baltimo | | | | | LIMITS? YES 2 NO |
| KER | 3031 Gwynns Fa | | | 10 | 11. ZIP CODE 21216 | | | S. | |
| BY FUNERAL DIRECTOR | 11. MARITAL STATUS t Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN (FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 NO | If yes, s | CENDENT OF HISPAN pecify Cuben, Maxica S 2 NO Specify | n, Puarto Rican, atc | | Black, WI | American Indian, alta, atc. Black |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | | | DECEDENT'S USUAL OCCUPATION (Globe wind of work done during most of working leb. KIND OF BUSINESS/INDUSTRY (Globe wind of work done during most of working leb. Do NOT use retired.) Uneral Director Mortuary | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | ranci | ar bire | 18. MOTHER'S NA | ME (First, Middle, Me | aiden Sumame) | · · · · · · · · · · · · · · · · · · · | |
| BE | Robert Evans Sarah Gray 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | |
| 2 | Edith Evans | | 1 | | Falls | | | | 21216 |
| | 20 METHOD OF DISPOSITION 1 22 Burlal 2 Cremation 3 Remov 4 Donation 5 Other (Specify) | ral from State A1 | PLACE OF DISPO other piece) DUTUS | Cemete | emetery, crematory or | | Balto. | Cnty | z. Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | 5# | 1712 Balto | W. Nort | h Avyi | n Carr | coll I | F/H |
| | 23. PART I. Entar tha diseases, or co | | | | | | reapiretory an | reat, | Approximata |
| | | | | | | | | Interval Batwean Onset and Death | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| NOL | Sequentially list conditions, if any, leading to immediate | | | | | | | | |
| CAI | cause. Entar UNDERLYING CAUSE (Diseasa or Injury | DUE TO (OR AS A | scule | ndu | reary) | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (OH AS A C | CONSEQUENCE | orj: | , | | | | |
| | PART II. Other aignificant conditions | contributing to death bu | t not reaulting | in the underlyin | ng causa given in | Part I. 24a, WA | S AN AUTOPSY | 24b. WE | RE AUTOPSY FINDINGS |
| EDICA | | | | | | PE | RFORMED? ES 2 \(\sum \text{NO} \) | CO | MPLETION OF CAUSE DEATH? |
| 2 | | | | | | _ | | | YES 2 NO |
| AN: | 25. WAS CASE REFERRED TO MEDICAL | | | 20.5 | PLACE OF DEATH ACH | neck anti-anni | | | |
| SICI | EXAMINER? | HOSPITAL: | tient 3 🗆 DOA | OTHER: | me 5 d flasidenca | | 1 | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 28s. DATE OF INJURY (Month, Day, Year) | 28b. TI | ME OF 28c. IN | JURY AT | 28d. DESCRIBE H | | CURED | |
| BY | 2 Accident Investigation | — At home, farm. | M t | YES 2 NO | 281. LOCATION (S | treet and Numbe | r or Rumi Routi | Number. | |
| TED | 4 Homicida datarmined | building, atc. (Specif | (y) | | | City or Town, | | | |
| COMPLET | one) | IAN: To the best of my knowle : On the basis of examination | | | | | | | d manner as stated. |
| BE CC | 296. SIGNATURE AND TITLE OF PERTIFIER | 1. D. 11 T | | | 29c, LICENSE NU | MBER | 29d. DAT | E SIGNED (MC | non pay war |
| 5 | 30, HAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (7/2 | w, Print) | | | | ld ! | 2170 |
| | 1 0 | | | | | | | | T |

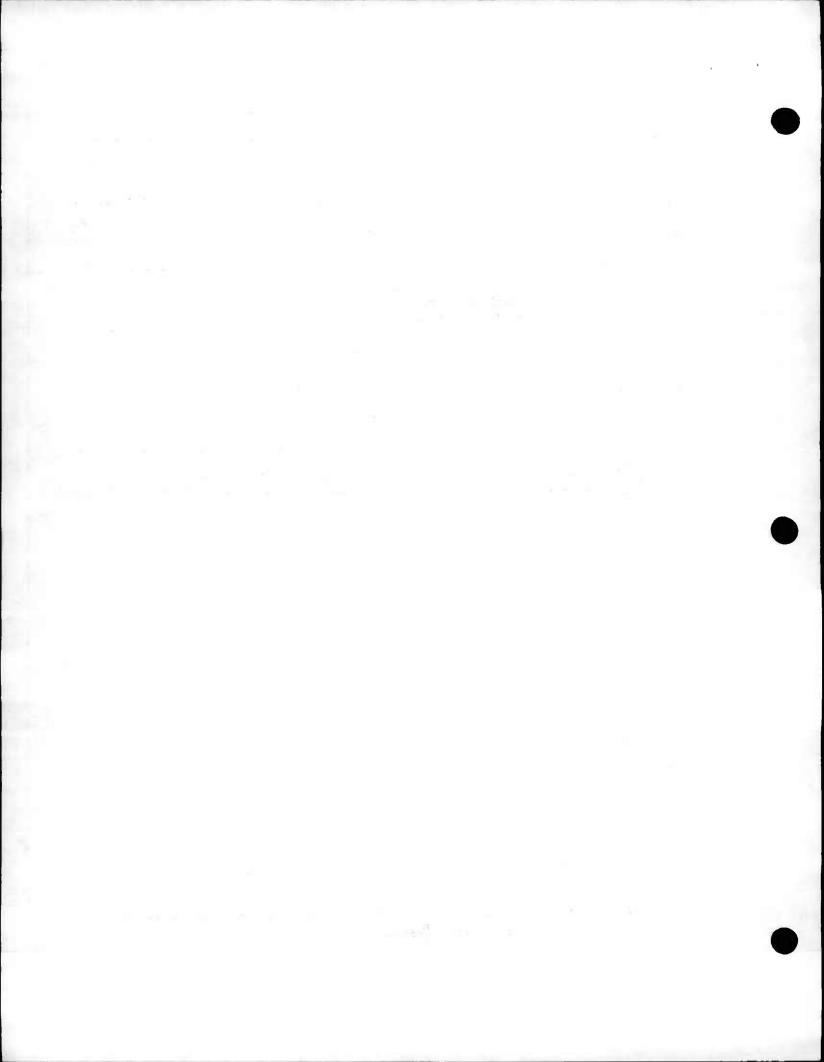


DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a construction of the c IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR | | QE. | -DIM | CAIL | - 01 | DLA | | H | EG. NO. | | | |
|---------------|---|---|----------------------|--|----------------------------------|------------------------|-------------------|--|---------------------------------|---|--------------------------------|-----------|-------------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF DEATH MONTH DAY YEAR | | | | 3. TIME OF DEATH |
| | | canklin | | | OLD, | _ | | | 12 | 11 | (| | 2:30 PM M |
| | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. last | | IF UNDER | 1 YEAR | HOURS | R 24 HRS. | 7. DATE OF E (Month, Da | y. Ybar) | | Country) | |
| | 215-28-1947 | 1 🔀 M 2 🗌 F | 58 | YRS. | | July 28, 1932 Maryland | | | | | | | |
| ~ | 9e. FACILITY NAME (If not institution, give at | | | | 9b. CITY | , TOWN | OR LOCATI | ION OF DE | ATH | | 9c. COU | NTY OF DE | ATH |
| 6 | NORTH ARUNDEL HOS | SPITAL AS: | SOCIATIO | ON | GI | LEN | BURN | IE | | | | A.A. | COUNTY |
| EC | 10s. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN (| OR LOCA | TION | | | | | | 10d. INSIDE CITY |
| DIRECTOR | MD. Anne | Arunde1 | | Gle | en Bu | ırni | e | | | | | | LIMITS? |
| 4 | 10e. STREET AND NUMBER | | | | | | f. ZIP COD | E | | 10g. CITIZEN OF WHAT COUNTRY? | | | IAT COUNTRY? |
| FUNERAL | 11 Ferndale Ave. | 21061 | | | | | | U.S.A. | | | | | |
| 5 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. AF FORCES? 1 🗗 YES 2 🗍 | | | | | | | | IIC ORIGIN? (S | | | 14. BACE | - American Indian, White, etc. |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Olvorced | IF YES CIVE W | AR OR DATES | | | | 2 K NO | | n, Puerto Rica: /: | n, etc.) | | Specify | : |
| | | /722 | -// |)) | | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDU: (Specify only highest grade | | (Gi | CEDENT'S Ive kind of a Do NOT us | work done | CCUPATI during mo | ON ost of work | ing | 16b. KIN | ID OF BUS | INESS/IND | DUSTRY | |
| ٦ | Elamentery/Secondary (0-12) College (1-4 or 5+) | | | | | | | | 7 | | c 5 | | |
| M | 12 None Su: | | | | pply Specialist 18. MOTHER'S NAM | | | | | | | fense | 9 |
| 8 | | | | | | | | | | . Market | | | |
| BE | George F. Fold, Sr | . • | 191 | NAIL ING | Anness | g /Streat | _ | | Ce M. Route Number, | | | Codel | |
| 2 | Adelaide Ann Fol | d | | | as | | and wante | o ricrair | HOUSE HOMOE, | only of fown | r, State, Est. | 7 0000) | |
| | 20a, METHOD OF DISPOSITION | | 20b. PLACE | | | | metery, cre | matory or | | 20c. LD0 | LDCATION — City or Town, State | | |
| | 20g, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Maryland Veterans | | | | | | | | eteru | | | | |
| | 21. SIGNATURE OF THE SERVICE LICENSEE | | | | | NAME A | ND ADDR | ESS OF FA | CILITY | | OWIIS | VIIIC | , IId. |
| | 1) 6.5 | | | | | _ | | | neral l | | | | =5× |
| | 23. PART i. Enter the diseases, or | 4 | | | | | | | | | | | MD 21061 |
| | shock, or heart feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Mula. DUE TO (| | | an (| re | chi (| C | Canc | - | - | | Interval Batween Onset and Death |
| CERTIFICATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| B | | d | | | | | | | | | | | 1 |
| MEDICAL | PERFORMED? ANA COI | | | | | | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| Ä | | | | | | 1772 | | | | | | | |
| D D | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | _ | OTHE | R: | | | eck only one) | | | | |
| PHYSICIAN: | 1 YES 2 NAME OF DEATH | 1 1 - Inpatient 2 1 28a. DATE OF | | 26b. TIN | | _ | JURY AT | Residence | 8 Other (S | | N HIRV OC | CHRED | |
| | 1 Natural 5 Pending | (Month, Da | | IN | JURY | W | ORK? | □ NO | 280. DESCH | IBE HOW II | NJUHT OC | COMED | |
| TED BY | 2 Accident investigation 3 Suicide 8 Could not be determined | 28a. PLACE Of building, | F INJURY — A1 ho | ome, farm, | street, fac | | | - ,v: | 281, LOCATION OF T | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | oute Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYS | ICIAN: To the best of ER: On the basis of ex | | | | | | | | | | | and manner as stated. |
| ш | 29b. SIGNATURE AND TITLE OF CONTINUE | my | 4 | | | | 29c. Lit | CENSE NUI | MBER | | 29d. DAT | E SIGNED | (Month, Day, Year) |
| TO B | | 119 | 1_ | | | | 10 | 256 | 54 | | | 12/12 | 190 |
| F | 30. NAME AND ADDRESS OF PERSON WI | | | | | | | | | | | 1 ' | |
| | YEONG H. OH, M.D. | ./1412 CR. | AIN HIG | HWAY | N., | #6A/ | GLEN | BUR | NIE, M | ARYL | AND 2 | 21061 | |
| | DEC 1 3 199 | 32. REGISTRA | BY SIGNATURE | Andel | 2 | | | | | | | | |





TO THE TO

ENDING PHYSICIAN: The iaw requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The Tink: After this certificate has been signed by if the state Dept. of Health and Nitem 28 is marked, or Item 23 shows any Inj

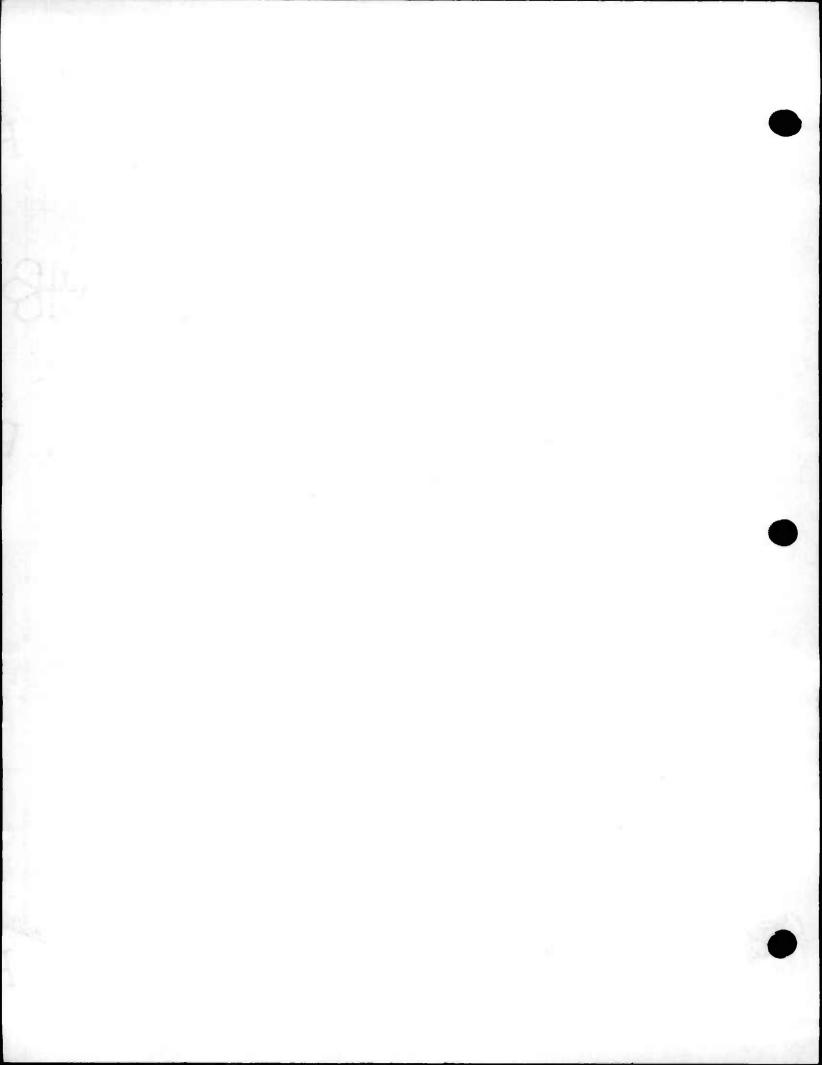
| I, 2, 3 should | | |
|----------------------------|--------------|-------------------------------------|
| t permit. Pages 1, 2, | | |
| e as the burial-transi | | |
| for us | | ej |
| should be detached | | otifled at once. |
| r, page 5 | | st be no |
| neral directo | | ic event, the medical examiner must |
| by the fu | removal. | dical exa |
| tely filled in | nation, or | t, the me |
| and comple | burial, crei | atic even |
| physician a | ne prior to | her traum. |
| e attending | fental Hygie | njury, or oth |
| £ | 2 | 7 |

| | FOR STATE REGISTRAR | STATE OF MARYLAN | | T OF HEALTH AN | D MENTA | AL HYGIENE REG. NO. | | | | |
|-----------------------|--|---|---|--|--|---|-----------------------|------------------------|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) Pauline Helen (| Comaric | | | MON | E OF DEATH TH DAY | | EAR 3. TIA | NE OF DEATH | |
| | 4. social security number 216–03–3602 | 5. SEX 6. AGE (In) | yrs. last birthday) # UNDI | R 1 YEAR F UNDER 24 H | | ember 10, E OF BIRTH hth, Day, Year) | 8. | BIRTHPLACE Country) | (State or Foreign | |
| OR | 99. FACILITY NAME (If not institution, give st 6511 Sefton Avenue | treet and number) | | y, town or Location of altimore | OF DEATH | | 9c. COUNTY | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | , | 10c. CITY, TOWN Balti | | | | | 1 . | NSIDE CITY JMITS? YES 2 NO | |
| FUNERAL | 100. STREET AND NUMBER 6511 Sefton Avenue | · · · · | | 101. ZIP CODE 21214 | | | 10g. CITIZEN USA | EN OF WHAT COUNTRY? | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | I.S. ARMED 13 2 NO ES X | WAS DECENDENT OF HI If yes, specify Cuben, M 1 YES 2 NO S | | e or No— 14. RACE — Amaricen Indien, Black, White, etc. | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) Homemaker 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker | | | | | | | TRY | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) Thomas Nemphos | | | | s NAME (First, Granit | , Middle, Malden S | umame) | | | |
| TO B | 196. INFORMANT'S NAME (Type/Print) Thomas L. Gounaris 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Rolling Green Court Timonium, Md. 21093 | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Remo 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | oval from State | LACE OF DISPOSITION (| Name of cemetery, cremator DEC.13, 1990 | | | ation — cit awn, M | y or Town, St | rte . | |
| | James F. Gladden | James & Bla | , | Leonard J. Ru | | 5305 Har | ford Ro | oad 212 | 14 | |
| | 23. PART I. Enter the diseases, or shock, or heert feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | List only one ceuse on eec | h line. | | | | | i | Approximate interval Between Onset and Death | |
| CERTIFICATION | disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediets cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Landiac Orrhythmias Due to (or as a consequence of): Cardiac Orrhythmias Due to (or as a consequence of): Oue to (or as a consequence of): Oue to (or as a consequence of): | | | | | | | | | |
| PHYSICIAN: MEDICAL CI | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN PERFOR 1 YES 2 | | | | | | | AVAIL COMP OF DE | AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE EATH? YES 2 PNO | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ОТН | | | | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 N | 28d. D | her (Specify) EŞÇRIBE HOW IN | JURY OCCUI | RED | | |
| TED BY | 2 Accident Investigation 3 Suicide S Could not be 4 Homicide determined | 28e. PLACE OF INJURY – building, atc. (Specify | | | 28f, LC | OCATION (Street ar ity or Town, State) | nd Number or | Rural Route N | lumber, | |
| COMPLETED | CONSTRUCTION CONTRACTOR CONTRACTO | SICIAN: To the bast of my knowled | | | | | | | manner as stated. | |
| TO BE C | | | | | | 29d. DATE SIGNED 25569 29d. DATE SIGNED 12/1 | | | 1, pey, Year) 90 | |
| | Francis L. Wiegmann | Jr. MD 8406 Ha | inford Rd. Bal | timore, Md. 2 | 1234 | | | / / | | |
| | DEC 13 1990 | July Devidor | HOLEN. | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | FOR STATE REGISTRAR | STATE OF MA | RYLAND / | DEPAR | TMENT | OF HI | ALTH DEAT | AND N | IENTAL | HYGIENE REG. NO. | | | | |
|----------------|--|--------------------------------|-------------------------|--|--------------------------|-------------|--------------|---------------|--------------|--------------------------------|------------|-----------------------------|---|--------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | | | OF DEATH | | YEAR | 3. TIME OF DEATH | |
| | SARAH | Α. | | GR | EEN | | | | MONTH 12 | 6 BA | | 990 | 8:15P | м |
| | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. last | | IF UNDER 1 | | IF UNDER | $\overline{}$ | 7. DATE | OF BIRTH | | | IPLACE (State or Foreign | 7 |
| | 216-24-3535 | 1 🗆 M 2 🔀 F | 77 | YRS. | MONTHS | DAYS | HOURS | MIN. | | , Day, Year) . 7/ 19 | 13 | Count | RYLAND | |
| | 9a. FACILITY NAME (If not institution, give : | street and number) | | | 9b. CITY, | TOWN O | LOCATIO | N OF DE | | | | | | |
| <u>۳</u> | Lauren Home | | | | P.a. | 1+1 | mor | 2 | | | | | | - 1 |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | | = |
| DIRECTOR | M D 100. COUNT | Υ | | 10c. CITY, TOWN OR LOCATION Baltimore | | | | | | | | 10d. INSIDE CITY LIMITS? | | |
| | | | | | | | | | | | | | Y YES 2 NO | _ |
| FUNERAL | 10e. STREET AND NUMBER | | | | | 107. | ZIP COOE | | 10g. CITIZEN | | | | WHAT COUNTRY? | |
| 則 | 1300 Lauren Street | | | | | Л., | | 121 | | | - | SA | | |
| 2 | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS OECEOENT FORCES? 1 | YES 2 X | MED | H | yes, spe | city Cuba | , Mexica | , Puerto I | ? (Specify Yea Rican, atc.) | or No— | Blac | E — American Indian, ik, White, atc. | |
| B | 3 Widowed 4 Olvorced IF YES, GIVE WAR OR DATES | | | | 1 YES X NO Specify: | | | | y: | | | Spec | Black | |
| 8 | 15. DECEDENT'S EDUCATION 16a, DE | | | | USUAL OC | CUPATIO | N | | 16b | . KIND OF BUS | INESS/IND | USTRY | | |
| ĒΙ | (Specify only highest grade Elementary/Secondery (0-12) | completed) College (1-4 or 5+) | (Gi | ive kind of . Do NOT υ | work done dise retired.) | luring mos | t of workin | g | | | | | | - 1 |
| 7 | Eletine many Secondary (G-12) | Contage (I-V OI O V) | | | | | | | _ | | | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTI | IER'S NA | ME (First, I | Middle, Maiden | Sumame) | | | |
| | EDWARD S. HAC | KETT | | | | | SO | РНТ | А НА | CKETT | 1 | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 191 | b. MAILIN | G ADDRESS | (Street a | | | | ber, City or Town | | Code) | | |
| 임 | HARRIETT GRAY | |] | L601 | CHI | LTC | N S | TRE | ET: | BALTI | MOR | Ε, | MD 21218 | |
| | 20a_METHOD OF DISPOSITION 1 XBurial 2 Cremation 3 Ran | norm State | 20b. PLACE other pla | OF DISPO | SITION (Na | me of cen | etery, cren | atory or | | 20c. LO | CATION — | City or T | own, State | |
| | 4 Donation 5 Other (Specify) . | | ĽM | | ION | | | | | BAI | MIT | ORE | , MARYLA | ND |
| | 21. BIGMATURE OF JUNERAL SERVICE L | ICENSEE | - / | 1 | | | D ADDRE | | | 1. 6. 60 | ים זאר | HME | RAL HOME | , |
| | KOLUL | () 1() | 1200 | 1 | | | | | | EIGHT | | | | |
| Ţ, | 23. PART L Enfor the diseases, ph | complications that | daused the de | With. Dp | | | | | | | | | Approximete | |
| | shock, or hear fellure | . List only one caus | on each line |). | | | | | | | | | Interval Betw Onset end D | |
| | IMMEDIATE CAUSE (Final disease or condition | W | | 700000 | | | | | | | | | 211 | |
| | resulting in death) | e | | | | | | | | | | | 724 | 45. |
| _ | _ | 14 | CVI | D . | | | | | | | >154 | - | | |
| <u>o</u> | Sequentially list conditions, If any, leading to immediate | OUENCE | DF): | | | | | | | | | | | |
| CAT | ause. Enter UNDERLYING | | | | | | | | | | | | | |
| Ē | CAUSE (Disease or injury that initiated events | DUE TO (| OR AS A CONSE | OUENCE (| OF): | | | | | | | | | |
| CERTIFICATION | reaulting in death) LAST | d | | | | | | | | | | | | |
| | PART II. Other significant condition | one contributing to | leath but not i | resulting | in the un | derivin | Cause | niven in | Part I. | 24a. WAS AN | AUTOPSY | 24 | b. WERE AUTOPSY FIND | INGS |
| CAL | | | | | , | | , | great its | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAU | |
| _ | | | | | | | | | | 1 YE\$ 2 | □ NO | | OF DEATH? | |
| Σ | | | | | | | | | — | | | | 1 YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 00 01 | ACE OF F | EATH (C) | eck only o | 00) | | | | |
| PHYSICIAN: MED | EXAMINER? | HOSPITAL: | | | OTHER | a : | | | | | | | | \neg |
| ΙλS | 1 YES 2 NO | 1 □ Inpatient 2 □ | | 28b, TI | | 26c. INJ | | sidence | _ | er (Specify) | N.ILIBY OC | CURED | | |
| | 1 Natural 5 Pending | (Month, De | y, Year) | | YJURY M | WC | RK7 | NO | | | | | | |
| ВХ | 2 Accident Investigation | 28e. PLACE OF | INJURY — At h | ome, farm | , street, fact | | | | 26f. LO | CATION (Street | and Numbe | or or Rura | I Route Number, | |
| ED | 3 Suicide 6 Could not be 4 Homicide datermined 28e. PLACE OF INJURY — At ho building, etc. (Specify) | | | | | | | | City | or Town, State) | | | | |
| H | 29a. CERTIFIER | | | | | | | | | | | | | |
| COMPLET | (Check only | SICIAN: To the best of a | | | | | | | | | | | n(a) and manner as state | and I |
| 00 | | | minution arous | (Alveetings | don, ni niy c | Aprilion, c | | | | a and praca, ar | | | | wu. |
| BE | 296. SIGNATURE AND TITLE OF CENTY | | 1 | | | | - | ENSE NU | | | 29d. DA | TE SIGNE | ED (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON V | THE COMPLETED CALL | | EM on T | no Drive | | U | 09 | 44 | | / | 4/1 | 0/90 | |
| - | The state of the s | | | | | - | . 1.4 | | | D 010 | 4.0 | | | |
| | Dr. Leeper | 1220 | N.Caro | $\tau \tau n$ | e St | , B | alt: | rom | e,M | D 212 | 13 | | | |
| | 31. DATE FILED (Month, Day, Year) | dula Davido | S SIGNATURE | | | | | | | | | | | |





DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | ges T | | |
|--|--|--|--|
| TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a mouns after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Ages 1. | be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burnal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - STATE REGISTRAR | STATE OF MARYLA | | ENT OF HEALTH AND | MENTAL HYGIEN | _ | 0 % 1 0 0 |
|----------------------|--|--|---|---|--|---------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) EUGENE | OCS GRIMA | ALDI | | 2. DATE OF DEATH DATE | 1 90 | 3. TIME OF DEATH 415 am M |
| ÷ | 4. SOCIAL SECURITY NUMBER 5 | 5. SEX 6. AGE (In) | YRS. MON | NDER 1 YEAR IF UNDER 24 HRS, THS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) | 9c, COUNTY OF | w JIRSEY |
| TOR | UNION MEMORIAL | | | BALTIMORE | | | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 1 0 - | WN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 420 CALVIN F | Avi | | 21218 | | 10g. CITIZEN OF | WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 12 YES 2 NO IF YES, GIVE WAR OR DATES | | | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Mexic 1 YES 2 NO Specif | CE — American Indian, ck, While, etc. | | |
| COMPLETED | | TION 1 mpleted) College (1-4 or 5+) | 6a. DECEDENT'S USU. (Give kind of work of life, Do NOT use reti | done during most of working | 16b. KIND OF BU | SINESS/INDUSTRY | |
| | 12 YRS. 17. FATHER'S NAME (First, Middle, Last) | Rimala; | LORGO | 18. MOTHER'S N. | AME (First, Middle, Maiden | Surname) | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) FAMILY RECO | | 196. MAILING ADD | RESS (Street and Number or Rural | | m, State, Zip Code) | |
| | 20a. METHOD OF DISPOSITION 1 | ni from State | other place) | N (Name of cemetery, cremetory or | 5RY BE | CATION City or | Town, State |
| | 21. SIGNATORE OF FUNERAL SERVICE LICEN | Ser A | | 22. NAME AND ADDRESS OF F. LUANS CHAPEL 2325 YORK | OF CHILLS | s nonium | |
| | 23. PART I. Enter the diseases, or cor shock, or heart failure. Lit IMMEDIATE CAUSE (Finei disease or condition resulting in deeth) | | | nter the mode of dying, suc | ch ea cardlec or reep | iretory arreat, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Obsess or injury | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | |
| SERTIF | that initiated events resulting in deeth) LAST | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other algnificant conditions Corp ham an | contributing to death but | | e underlying cause given in | Part I. 24a. WAS AN PERFOI | RMED? | NAME AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | Im | 26. PLACE OF DEATH (C | heck only one) | | |
| PHYSI | 1 | Impatient 2 ER/Outpet 28e. DATE OF INJURY (Month, Day, Year) | | Nursing Home 5 - Residence | 6 Other (Specify) 28d. DE\$CRIBE HOW | INJURY OCCURED | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specif) | At home, farm, stree | | 28f. LOCATION (Street City or Town, State | | l Floute Number, |
| COMPLETED | CONTROL OF THE CONTRO | | | the time, date and place, and du my opinion, death occured at th | | | e(a) and manner as stated. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | ND | | 29c. LICENSE NO. |) 3 G | 29d. DATE SIGNI | ED (Month, Day, Year) -11-80 |
| ۲ | 30. NAME AND ADDRESS OF PERSON WHO A - ICFOURY 31. DATE FILED (Month, Day, Year) DEC 13 1990 4 | 201 6. | TH (ITEM 27) (Type, Prin | ent, BAC | 10,00 | 2/2/ | 8 |
| | DEC 13 1990 4 | 32. REGISTRAR'S SIGNAL | NOTE BE | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | |
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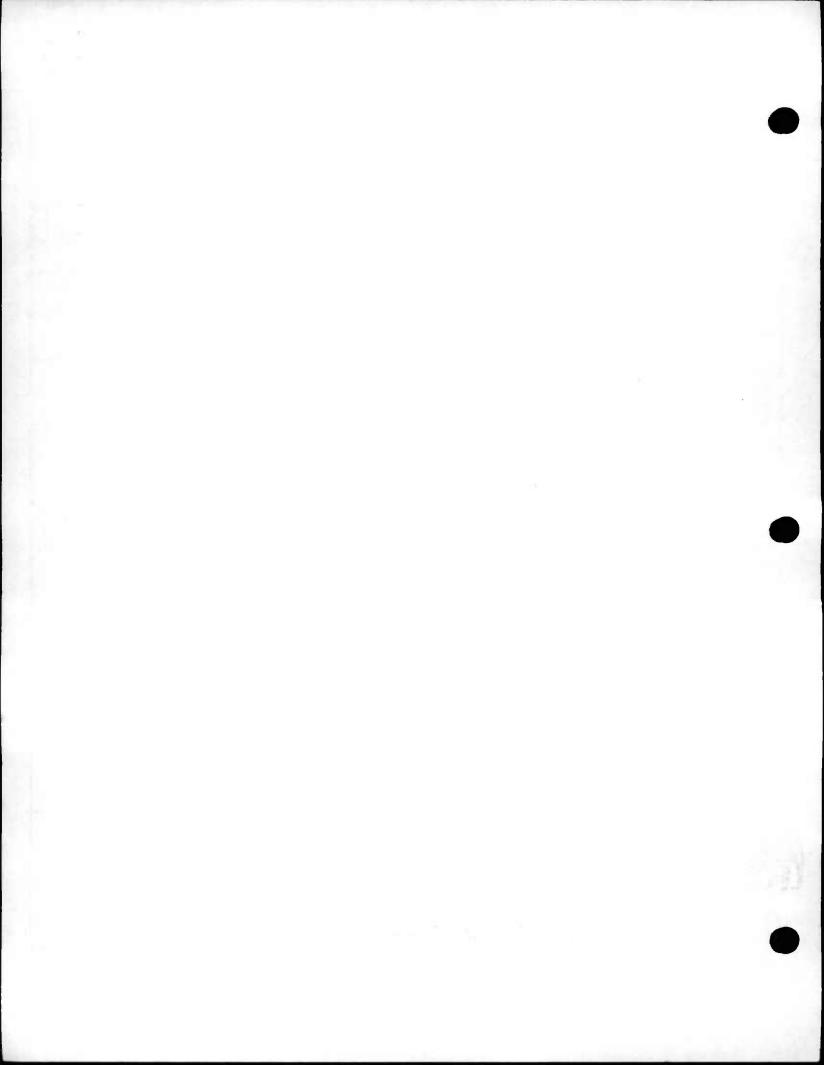
TO THE HESPEAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-fours after death. Page 6 may be retained by the hospital or attending physician.

HETUREAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should safe in 2 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| STATE OF | MARYLAND / | DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|----------|------------|------------|-----------|-----|--------|----------|
| | CI | ERTIFICATE | OF DEAT | H | | REG. NO. |

| FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | | ENT OF HEALTH A | | AL HYGIENE REG. NO. | 0 04105 |
|--|--|---|---|---|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last | STERHEN C | GRIPPO | | 2. DATI | E OF DEATH TH 12 DAY // | YEAR 5.53 PM |
| 4. SOCIAL SECURITY NUMBER 145–42–8442 | 6. SEX 6. AGE (In y | | INDER LYEAR IF UNDER 2 THE DAYS HOURS | | OF BIRTH (h.,(Day, Year) | BIRTHPLACE (State or Foreign Country) New Jersey |
| 9a. FACILITY NAME (If not institution, give | etreet and number) | 96. | Balt. | N OF DEATH | 9c. COU | NTY OF DEATH |
| 10a. STATE 10b. COUN | m imore | 10c. CITY, TO | WIN OR LOCATION | | | 10d. INSIDE CITY UPPITS? 1 d 2 ∭ NO |
| 100. STREET AND NUMBER 27 Top View Cour | t | | 101. ZIP CODE 21207 | 7 | | S.A. |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. Never Married 14. WAS DECEDENT EVER IN U.S. ARMED 15. Never Married 16. Never Married 17. Never Married 18. Never Married 19. Never Married | | | 13. WAS DECENDENT OF If yes, specify Cuber 1 YES 2 HO | 14. RACE — American Indian, Black, White, etc. Specify: White | | |
| 15. DECEDENT'S ED (Specify only highest grad Etementary/Secondary (0-12) | UCATION 16 completed) College (1-4 or 5+) | Give kind of work life. Do NOT use ret | done during most of working | 16 | b. KIND OF BUSINESS/INT | DUSTRY |
| 12 | | | | | Arundel Sig | n , Inc. |
| 17. FATHER'S NAME (First, Middle, Last) Frank | A. Gri | nno | | er's name (First, / a | Middle, Maiden Surname) T | Dycha |
| 19a. INFORMANT'S NAME (Type/Print) | A. UII | | PRESS (Street and Number of | | nber, City or Town, State, Zip | <u> </u> |
| Middlesex Funera | 1_Home | 528 Bour | d Brook Roa | ad, Midd | lesex, N.J. | 08846 |
| 20a. METHOD OF DISPOSITION 1 | moval from State | ther place) | N (Name of cometery, crome rematory | | | Ridge, N.J. |
| 21. SIGNATURE OF FUNERAL SERVICE LETTERS TO FEI | 7 | | Leonard J 5305 Harf | | Inc. ,Baltimore, | |
| 23. PART I. Enter the disease, or abook, or heart failure immediate cause (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST | a | C er a b ONSEQUENCE OF): | | , | rrhage | Approximate interval Between Onset and Death |
| PART II. Other significant condition | ons contributing to death but | not resulting in the | e underlying cause g | ven in Part i. | 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 PHO | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PAO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 26. PLACE OF DE | ATH (Check only | one) | |
| 1 TES 2 NO | HOSPITAL: | | HER: Nursing Home 5 ☐ Res | idenca 6 🗆 Oti | her (Specify) | |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF | 28c. INJURY AT WORK? M 1 YES 2 | | EŞCRIBE HOW INJURY OC | CURED |
| 3 Suicide 6 Could not b | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, stree | t, factory, offica | 281. L.C | CATION (Street and Numberly or Yown, State) | r or Rural Route Number, |
| toward only | SICIAN: To the best of my knowled | | | | | ated, the cause(a) and manner as stated. |
| 206. SIGNATURE AND TITLE OF GERTIF | Shepit | nD | 29c. LICE | NSE NUMBER | 29d. DAT | TE SIGNED (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON V | . Shevit | H (ITEM 27) (Type, Prin | 0 | Sin | ai H | espital |
| 31. DATE FILED (Month, Day, Year) DFC 1 9 199 | 32. BEGISTRAR'S SIGNAT | - Pandelle | | | | / |



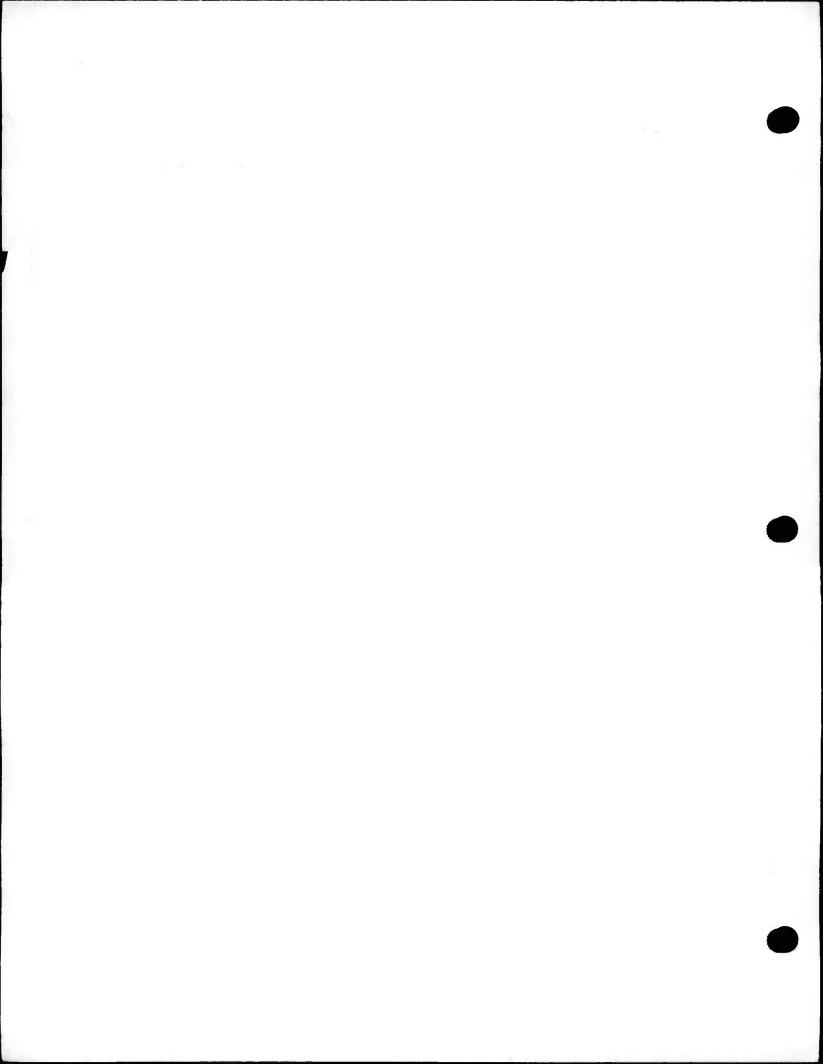
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ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-rours after death. Page 6 may be retained by the hospital or attending physician.

The law is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be required by the burial-transit permit. Pages 1, 2, 3 should be required by the burial-transit permit. Pages 1, 2, 3 should be required by the burial-transit permit. Pages 1, 2, 3 should be required by the burial-transit permit.

| STA | E OF MARYLAND / DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|-----|----------------------------|-----------|-----|--------|----------|
| | CERTIFICATE | OF DEAT | ГН_ | | REG. NO. |
| | | | | | |

| , the | ansa. Thionas | £ | | | | |
|------------|--|---|--|--|-------------------------------|--|
| 1 | 25 | | | -17 | | |
| * 7 | 01/11/12 | | | | | 90 34170 |
| \$ | 1 - FOR STATE REGISTRAR | TATE OF MARYLAND C | | IT OF HEALTH AND I E OF DEATH | MENTAL HYGIENE REG. NO. | |
| | 1. OECEOENTI'S NAME (First, Middle, Last) | E | CPI | 100 | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH |
| | 4, SOCIAL SECURITY NUMBER 5.5 | SEX 8. AGE (In yrs. le | ast birthday) IF UND | ER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BIRTHPLACE (State or Foreign |
| | the same of the same | DM2 DF 78 | YRS. MONTH | | JAN /181 19 | 12 Country Y |
| | 9a. FACILITY NAME (If not institution, give street a | and number) | 9b. CI | TY, TOWN OR LOCATION OF DI | | C COUNTY OF DEATH |
| 000 | RESIDENCE OF DECEDENT | JRS HOS | | BALIIM | ORE CITY | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, TOW | | | 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO |
| | 10e. STREET AND NUMBER | | I Balt | imore 101. ZIP CODE | 10 | og. CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 1116 Myrtle Ave | | | 21201 | | U.S.A. |
| | 1 Never Married 2 1 Married | WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO 1 | 3. WAS DECENDENT OF HISPAI If yes, specify Cuban, Mexico 1 VES 2 NO Specif | m, Puerto Rican, etc.) | No 14. RACE American Indian, Black, White, atc. Specify: |
| ЭВУ | 3 Wildowed 4 Divorced | World War I | | | | Black |
| | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondary (0-12) | ON 16a. 5 pleted) | DECEDENT'S USUAL (Give kind of work dor fe. Do NOT use retired | OCCUPATION ne during most of working f.) | 16b. KINO OF BUSINE | |
| COMPLETED | Co | 11ege 4 | Teach | er | Departm | ore City ment of Educatio |
| | 17. FATHER'S NAME (First, Middle, Last) Williams T. Gro | | | Lovie | ME (First, Middle, Maiden Sum | name) |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING ADDRI | SS (Street and Number or Rural | | tete, Zip Code) |
| 욘 | Eunice M. Gross | | | | | MD 21201 |
| | 20s, METHOD OF DISPOSITION VA Buriel 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | 1rom State 20b. PLAC | place) | (Name of cemetery, crematory or | | ings Mills, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | EE JETD V | 1 2 | 2. NAME AND ADDRESS OF FA | CILITY Nutter | Funeral Homes, |
| CAB | Herbert (| 2 mutter | i | 2501 Gwynns Baltimore, | Falls Par Marvland | kway 21216 |
| | 23. PART i. Enter the diseeses, or com shock, or haert feliure. List | plications that caused the conly one cause on each li | death. Do not en | | | ory arreat, Approximata interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | CEPTICE | LIM | METH | RESISTA | Onset and Death |
| 1 | resulting in daeth) a | DUE TO (OR AS A CONS | EQUENCE OF): | | STA | APH AUREUS |
| TION | Sequentially list conditions, b | DUE TO (QR AS A CONS | EQUENCE OFF | AU FIS | TULA GA | AFT |
| | If any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury | EUD (| TAGE | RENA | AL DIS | EASE |
| CERTIFICA | that initiated eventa reculting in death) LAST | DUE TO (OR AS A CONS | EOUENCE OF): | | | |
| | d | | | | | |
| MEDICAL | PART II. Other aignificent conditione co | MBUIT | t resulting in the | underlying cause given in | PERFORME | D? AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDI | | | | | 1 _ YES 2 _ | OF DEATH? 1 YES 2 NO |
| N. | | | | _ | | |
| PHYSICIAN: | | OSPITAL: | 3 DOA 4 D | 26. PLACE OF DEATH (C | 2000000 CUP-20 | |
| PHYS | 27. MANNER OF DEATH | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF | 26c. INJURY AT WORK? | 26d. DESCRIBE HOW INJU | JRY OCCURED |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | M | 1 YES 2 NO | | |
| TED | 3 Suicide 6 Could not be 4 Homicida determined | 26e. PLACE OF INJURY — At building, atc. (Specify) | nome, rarm, street, | встогу, отнов | City or Town, State) | Number or Rural Route Number, |
| COMPLETED | Constant only | N: To the best of my knowledge, | death occurred at th | e time, data and place, and du | a to the cause(a) and manner | r aa stated. |
| WO. | | on the basis of axamination and/o | or investigation, in n | ny opinion, death occured at the | time, data and place, and d | us to the cause(s) and manner as stated. |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | MA - 1/ | N. J | 29c.N.ICENSE NU | MBER 21 | 9d. DATE SIGNED (Month, Dey, Year) |
| 2 | 30, NAME AND ADDRESS OF PERSON WHO CO | OMPLETED CAUSE OF DEATH (I | TEM 27) (Type, Print) | D 16 | 165 | 12/10/90 |
| | 1940 W. BAL | MURE S | T. BF | CTIMORE | = 40 | 21223 |
| | 31. DATE FILED (Month, Day, 16er) | 32. REGISTRAR'S SIGNATURE | | | / | |

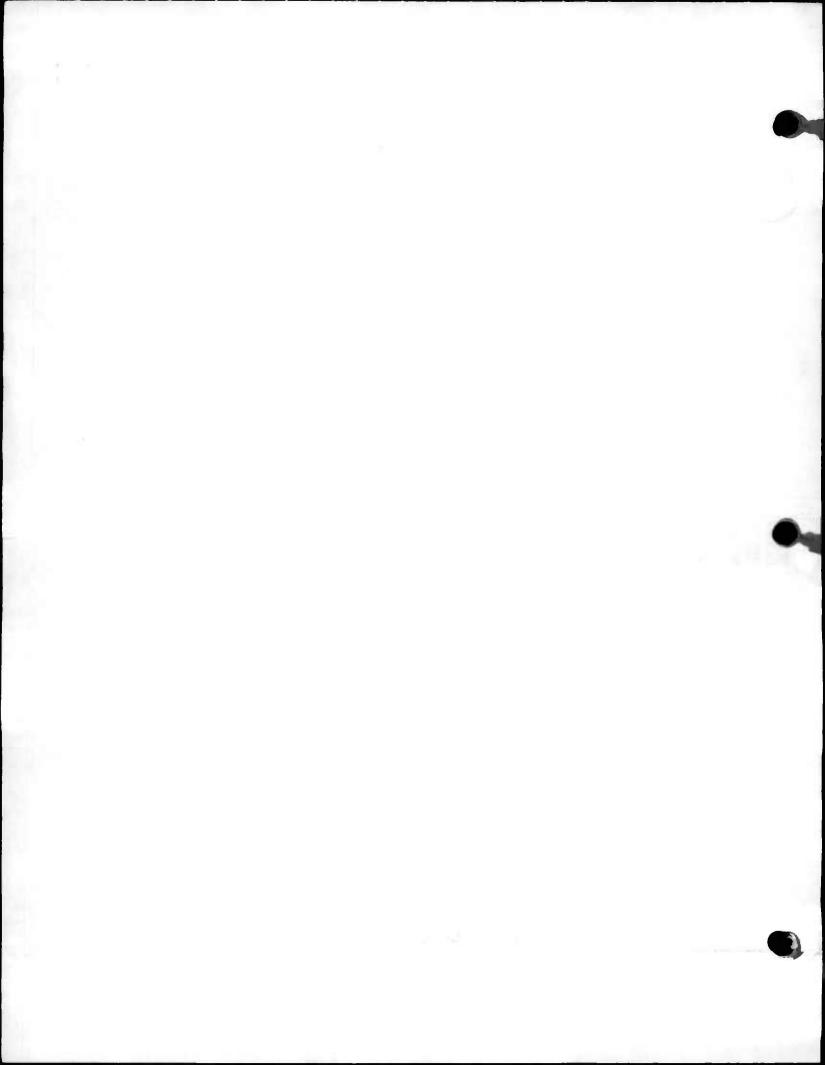


| BALTIMORE, MARYLAND 21203-3146 | Let nours after death. Page 6 may be retained by the hospital or attending physic filled in by the funeral director, page 5 should be detached for use as the burial- nn, or removal. The medical examiner must be notified at once. | |
|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within car, yours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans be filed within 72 hours after death with the State Dept. of Heath and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | 1 - STATE REGISTRAR | OINTE OF MARTIE | CERTIFICA | TE OF DEATH | REG. NO |). | | | | | | | |
|---------------|--|---------------------------------|----------------------------|------------------------------------|--|---------------------|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | DAY YEA | 3. TIME OF DEATN | | | | | | |
| | HANEDER | many E | LIZASETTH | HANCOCK | | 7 199 | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (I | yrs. last birthday) IF UN | IDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. B | IRTHPLACE (State or Foreign | | | | | | |
| | 219- 22- 4245 | 1 - H 2 BF | O YRS. MONT | HS DAYS HOURS MIN. | 2-21- | | ma | | | | | | |
| | 9a. FACILITY WAME (If not institution, give | | | CITY, TOWN OR LOCATION OF E | | 9c. COUNTY C | | | | | | | |
| OR | UNIVERSITY OF M | ARTLAND CANC | CR CNIR | BALTIMORE, | MD. | BAZ | 50. CITY | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | 10. OUTV TOU | VN OR LOCATION | | | 10d. INSIDE CITY | | | | | | |
| E | na. SIAIE | | | BAltimo | 00 | | LIMITS? | | | | | | |
| | 10a, STREET AND NUMBER | , | ^ | 10f. ZIP CODE | <i>EE</i> | Lan- OITITEN | 1 | | | | | | |
| RA | 1 / / | of a crefle | 13 -013 | 2/2 | +7 | lug. Cilizen | 15 d | | | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | UNE ADMED | 13. WAS DECENDENT OF HISPA | ANIC ODICING (Secolar V | No 14.5 | RACE — American Indian, | | | | | | |
| F | 1 Neyer Married 2 Married | FORCES? 1 YES | 2 2 NO | If yes, specify Cubari, Mexic | an, Puerto Ricen, etc.) | | Black, White, etc. | | | | | | |
| ВУ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | TES | 1 TYES 2 THO Spec | ify: | | Specify: | | | | | | |
| G | 16. DECEDENT'S EDI | CATION | 16a. DECEDENT'S BSUA | | 16b. KIND OF BI | USINESS/INDUSTI | RY | | | | | | |
| E | (Specify only highest grad Elamentary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT use retin | one during most of working ed.) | | | | | | | | | |
| P | | | Home. | MAKER. | | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 1/1/ | | 18. MOTHER'S N | AME (First, Middle, Maide | n Surname) | / | | | | | | |
| BEC | HHrEd 9 | 8114 | - 44 | In | TRUL A | Du (1 | TEK . | | | | | | |
| | 19a. INFORMANT'S NAME (Typo/Print) | | 11 10 | RESS (Street and Number or Rura | | wn, State, Zip Code | 0) | | | | | | |
| 2 | JOBN HANC | ck | 643 Ce | · Koracret | e ave. | | | | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rer | 20b. | PLACE OF DISPOSITION | (Name of birming/srematory of | 20c. j | OCATION - City | or Town, State | | | | | | |
| | 4 Donetion 5 Other (Specify) | noves from outs | Kee | Cornedia | _ | A110. | md. | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | 22. NAME AND ADDRESS OF I | ACILITY PLEVE | e x | leure | | | | | | |
| | Maries m | Mason | روه | 3405 001 | marke | in 31. | 7 () 750 | | | | | | |
| | 23. PANT L Enter the diseases, or | complications that caused | | | AND | FC 6 | Approximate | | | | | | |
| | ahock, or heart fellure | . List only one cause on ea | ich lina. | | | | Interval Between Onset and Death | | | | | | |
| | disease or condition resulting in death) a. CARDIO RESOIR WORY & REST, | | | | | | | | | | | | |
| | nesulting in death) a. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 7 | BREAST CANCER 31/2. | | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, If any, leading to immediate b. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| B | cause. Enter UNDERLYING | G | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | | | |
| ERI | resulting in death) LAST | d | | | | | | | | | | | |
| | PART II. Other significant condition | ons contributing to death b | ut not resulting in th | underlying cause given i | n Part I 24s WAS 4 | IN AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | | | |
| MEDICAL | | | | | PERF | ORMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | |
| | | | | | 1 🗀 YE\$ | 2 (2)-410 | DF DEATH? | | | | | | |
| Σ | | | | | — | | 1 TYES 2 NO | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | | |
| 2 | EXAMINER? | HOSPITAL: | | HER: | | - | | | | | | | |
| 7 | 27. MANNER OF DEATH | 26a. DATE OF INJURY | 26b. TIME OF | Nursing Home 5 Residence | 28d, DESCRIBE NOV | / INJURY OCCUR | -n | | | | | | |
| | 1 Netural 5 Pending | (Month, Day, Year) | INJURY | WORK? M 1 YES 2 NO | 200. 5200 | | | | | | | | |
| BY | 2 Accident Investigation 3 Suicide 6 Could not be | 26a PLACE OF INJURY | — At home, farm, street | | 261, LOCATION (Street | et end Number or F | tural Route Number. | | | | | | |
| 0 | 3 Suicide 6 Could not be 4 Nomicide determined | building, etc. (Spec | elfy) | | City or Town, Sta | | • | | | | | | |
| E | 29a. CERTIFIER | | | | <u> </u> | | - | | | | | | |
| MP | (Check only | SICIAN: To the best of my know | | | | | | | | | | | |
| COMPLET | | NER: On the basis of axaminatio | . and investigation, in | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIF | | 70 | 29c. LICENSE N | | 29d. DATE SI | GNED (Month, Day, Year) | | | | | | |
| | | | | // 1/// | v < () | 17 | | | | | | | |
| | 111200011 | Eggsh 77, | | DI3 | 7 3 0 | 1,,, | 19/90 | | | | | | |
| 5 | 30. NAME AND ADDRESS OF PERSON W | THO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Print | MERNIL | 5. EGURIN, | mp. | 19/90 | | | | | | |

31. DATE FILED (MONTH, Day, Year)

DHMH-16 Rev 1/89



FOR

| | lea | F | |
|---|---|---|---|
| | SPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24-mours after deat | NERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun | and the state with the Charles and Marchal Marchal Marchall Companies of the Companies of remarks |
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trith. Page 6 may be retained by the hospital or attending physician.

There is the burlat-transit permit, Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hoss TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|---------------|--|--|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | |
| | VICTOR H. HODGIA, JR. DEC. 10, 1990 7:55A.M. | | | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH 6. BIRTHPLACE (State or Foreign | | | | | | | | | | |
| | 21642 0661 1XM2 F 46 YRS. MONTHS DAYS HOURS MIN. JUNY 1944 MARYLAND | | | | | | | | | | |
| | 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | |
| DIRECTOR | 1502 BIRCH COURT BLAIR HARFORD | | | | | | | | | | |
| EC | 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | | | | | | |
| E | MARYLAND HARFORD BELAIR 1 VES 25KNO | | | | | | | | | | |
| | 104. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | |
| FUNERAL | 1502 BIRCH LOURT 21014 U.S.A. | | | | | | | | | | |
| S | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No — 14. RACE — American Indian, | | | | | | | | | | |
| BY F | 1 Never Married 2 Married FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES FORCES? 1 YES 2 NO Specify: Black, White, atc. Specify: Specify: | | | | | | | | | | |
| | 1 05/1/2 | | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | | |
| | Elamentary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) | | | | | | | | | | |
| × | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Last) | | | | | | | | | | |
| | VICTOR H- HOOGIN, SR. GERTRUDE S. SCHWARTZ | | | | | | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print). 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) | | | | | | | | | | |
| 2 | FAMILY RECORDS SAME AS ABOVE | | | | | | | | | | |
| | 20s, METHOD OF DISPOSITION 20b, PLACE OF DISPOSITION (Name of cameters, crematory or 20c, LOCATION — City or Town, State | | | | | | | | | | |
| | 19 Burial 2 Cremetion 3 Removal from Stata 4 Donation 5 Other (Specify) State BELAIR DEMORIAL GAR BELAIR DO. | | | | | | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 5. VANS C. H. P. L. O. C. L. | | | | | | | | | | |
| | | | | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | |
| | shock, or heart failure. List only one coline on each line. | | | | | | | | | | |
| | disease or condition Acute Leukemia | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| _ | | | | | | | | | | | |
| CERTIFICATION | Sequantially liet conditions, If any, leading to immediate | | | | | | | | | | |
| S | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | | |
| | that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ER | resulting in death) LAST | | | | | | | | | | |
| | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | |
| DICAL | PERFORMEO? AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | | | | | | |
| ED | 1 □ YES 2 NO OF DEATH? | | | | | | | | | | |
| Σ | 1 Tes 2 No | | | | | | | | | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | |
| PHYSICIAN: ME | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | |
| H | 27. MANNER OF CEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED | | | | | | | | | | |
| ВУ Р | 1 Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation | | | | | | | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28b. PLACE OF INJURY — At home, farm, street, factory, office City or flown, State) | | | | | | | | | | |
| I | 4 Homicide determined | | | | | | | | | | |
| PLE | 29a. CERTIFIER (Check only (Ch | | | | | | | | | | |
| COMPLETED | One) 2 MEDICAL EXAMPLER: On the basis of stamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| | 29b. SIGNATURE AND TITLE OF CANTUMER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| BE | 814 Browns M4026 DIC 11 1990 | | | | | | | | | | |
| 5 | 30. NAME AND ADDRESS OF DERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | |
| | DR. ERIC ROWIRSKY JOHNS HOPKINS HOSPITAL | | | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | | |
| | DEC 1 2 1990 Like Veriday Parolette | | | | | | | | | | |

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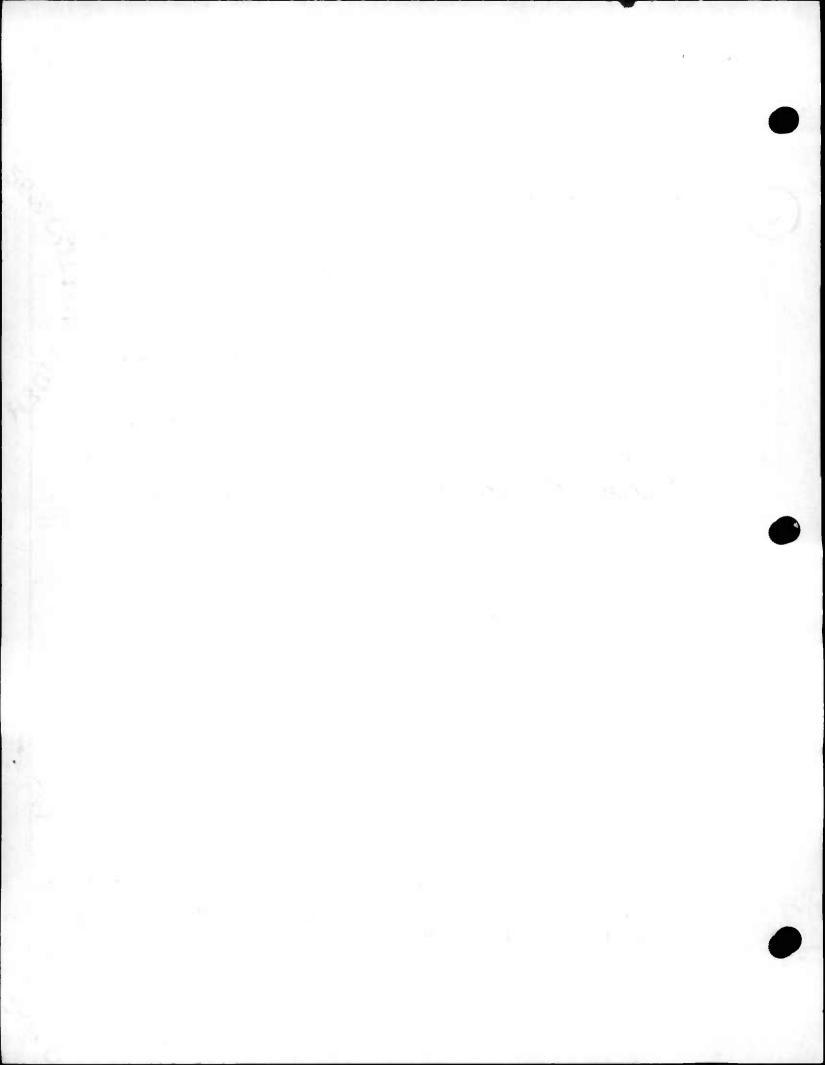
| BALTIMORE, MARYLAND 21203-3146 | after death. Page 6 may be retained by the hospital or attending physician. | y the funeral director, page 5 should be detached for use as the burial-transit permit noval. | cal examiner must be notified at once. | ייים מדדן ומייסט דים מד |
|--|--|---|--|-------------------------|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within common after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It from 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | FOR 1 - STATE REGISTRAR | | STATE OF ! | MARYLA | | ARTMEN IFICAT | | | | MENTAL | HYGIENI REG. NO. | E | | |
|---------------|---|--------------------------------|---------------------|-------------|--------------------|---|-------------|---------------|-----------|--|---------------------|------------|---------------|--|
| | 1. DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | OF DEATH DA | | YEAR | 3. TIME OF DEATH |
| 1 | J. | AMES | Frank | | но | SKI | | | | 12 | 1 | | 90 | 10:20 A M |
| 1 1 | 4. SOCIAL SECURITY NUMB | | 5. SEX | 8. AGE (// | n yrs. last birthd | | R 1 YEAR | IF UNDE | R 24 HRS. | 7. DATE C | F BIRTH | | 8. BIRTI | HPLACE (State or Foreign |
| 1 1 | 215-03-2291 | | 1 🖾 M 2 🗌 F | 82 | YR | S. MONTHS | DAYS | HOURE | MIN. | (Month, Dey, Year) Country) 6-16-1908 Maryland | | | m arvland | |
| 1 1 | 9e. FACILITY NAME (If not in: | | treet end number) | 02 | | 9b. CIT | Y, TOWN | OR LOCAT | ION OF DE | | , 1,00 | 9c. COUI | NTY OF E | |
| Œ | 301-Fourth | Ave. | S.W. | | | G | 1en | Burn | ie | | | Anne | Ar | undel |
| 181 | RESIDENCE OF DEC | EDENT | | | | | | | | | | | | |
| DIRECTOR | 10a. STATE | 10b. COUNT | 1 | | 10c. | CITY, TOWN | OR LOCA | TION | | | | | | 10d. INSIDE CITY LIMITS? |
| | Md. | Ann | e Arunde | L | G | len B | urni | e | | | | | | 1 TYES 2 A NO |
| FUNERAL | 10e. STREET AND NUMBER | | | | | | 10 | 1. ZIP CO | DE | | | 10g. CITI | ZEN OF | WHAT COUNTRY? |
| 1 1 1 | 301-Fourth | Ave. | S.W. | | | | | 2106 | 1 | | | U.S | S.A. | |
| 15 | 11. MARITAL STATUS | | 12. WAS DECEDER | | | 13 | | | | NIC ORIGIN | ? (Specify Yes | or No- | 14. RAC | E — American Indian, |
| | 1 Never Merried 2 3 Widowed 4 Divo | | IF YES, GIVE | | | - 1 | | | Specifi | | reall, every | | Spec | olfy: |
|) BY | | | W.W.I | [| | | | | | | | l | | nite |
| COMPLETED | | EDENT'S EDU y highest grade | | | 16a. DECEDEN | NT'S USUAL of work done of use retired. | during me | | dng | 16b. | KIND OF BUS | SINESS/INC | DUSTRY | |
| " | Elementary/Secondary (0 | 12} | College (1-4 or 5 | +} | | | • | | | , | 1 0 | 00 T | T A | |
| ₹ | 12 | | No | | Lon | g Sho | rman | • | | | cal 8 | | . L.A | • |
| | 17. FATHER'S NAME (First, M | | | | | | | | | | fiddle, Maiden | _ | | 100 |
| BE | | nown | | | | | | 1 | ulia | | Bong | | | |
| 2 | 19e. INFORMANT'S NAME (7 | | | | | | | | | | | | | 01061 |
| | Andrew Po | | | 1 | | OO Fourth Ave. S.W. Glen Burnie, Md. 21061 ISPOSITION (Name of commetery, cremetory or 20c. LOCATION — City or Town, State | | | | | | | | |
| | 20g. METHOD OF DISPOSIT | on 3 🗆 Rem | oval from State | 206 | other place) | | | | | .1. | 11 | | | |
| | 4 Donation 5 Other | | revess / | 9- | Glen I | | | | ESS OF FA | | 61 | en B | urnı | e,Md. |
| | dia | 1// | 21. | 11 | | / " | Sing | leto | n Fu | neral | Home | | | |
| | TYLENGE | W/ |) In | 00 | 11 | | 1 Se | cond | Ave | . S.W | . Gle | n Bur | rnie | ,Md. 21061 |
| | 23. PART i. Enter the d | | complications th | | | Do not ent | er the me | ode of d | ying, suc | ch aa card | lec or resp | ratory er | rest, | Approximata interval Between |
| | IMMEDIATE CAUSE (Fig | | List Only Ona Ca | use on a | acii iiia. | | | | | | | | | Onset and Death |
| | disease or condition resulting in death) | | . C | 2m | 1 | George Stomar | | | | | | | | |
| | resulting in country | • | DUE TO | OR AS A | CONSEQUENC | | | | | | | | | |
| z | ter carrier | | b | | | | | | | | / | | | |
| CERTIFICATION | Sequentially list condit if any, leading to imme | diata | DUE TO | OR AS A | CONSEQUENC | CE OF): | | | | | | | | |
| 3 | cause. Enter UNDERLY CAUSE (Disease or inju | | с | | | | | | | | | | | |
| E | that initiated events resulting in death) LAS | | DUE TO | OR AS A | CONSEQUENC | CE OF): | | | | | | | | |
| E E | resulting in destin) LAS | " (| d | | | | | | | | | | | |
| | PART II. Other algorifica | ent condition | ns contributing t | o death b | out not reault | ing in the | underlyir | ng Cause | given in | Part i. | 24a. WAS AN | AUTOPSY | 24 | b. WERE AUTOPSY FINDINGS |
| SAL | | | _ | | | | | | | | PERFO | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | | | | | | | | | | — i | 1 TYES | I I NO | | OF DEATH? |
| | | | | | | | | | | — | | | | 1 YES 2 NO |
| A A | 25. WAS CASE REFERRED 1 | MEDICAL | | | | | 24.5 | N ACE OF | DEATH # | heck only or | na l | | | |
| PHYSICIAN: | EXAMINER? | O MEDICAL | HOSPITAL: | | S. V | отн | ER: | | | | · | | | |
| 148 | 1 YES 2 NO | | 1 Inpatient 2 | | | TIME OF | - | me 5 □ | Residence | 8 Othe | CRIBE HOW | IN HIRY OF | CURED | |
| | | Pending | | Day, Year) | 1 | INJURY | W | ORK? YES 2 | □ NO | 100. 02. | JOHE HOW | | JOUNED | |
| B | 2 Accident | Investigation | 28e. PLACE | OF INJURY | r — Al home, fr | arm street f | | | | 281 100 | ATION (Street | and Numbe | er or Rune | I Route Number, |
| | 3 Suicide 8 4 Homicide | Could not be determined | building | , etc. (Spe | clfy) | ,, . | 201017, 011 | | | | or Town, State | | JI 01 1 101 0 | Tradic Harroot, |
| PLET | 29e, CERTIFIER | | | | | | | | | | | | 10-1 | |
| COMPLETED | (Check only | | SICIAN: To the best | | | | | | | | | | | 7. K. T. C. S. S. S. S. S. S. S. S. S. S. S. S. S. |
| SE COM | | | | Armiliatio | AI AUCYOL IUASI | igation, in m | y opinion, | | | | and place, a | | | e(e) end menner as stated. |
| BE | 296. SIGNATURE AND TITL | E OF CERTIFIE | IN . | 1 | _ | 1 | _ | 29c. i.) | CENSE MU | O K | 20 | 29d. DA | TE SIGNE | ED (Month, Day, Year) |
| - m | | | HO COMPLETED CA | 1 | | | | | VI | 15-6 | 1 | | 15 | -11-10 |
| 일 | | | | | | CT D. L | | | 1 | | | | | |

1600 South Crain Hwy. /Suite 306 Glen Burnie, Md.



Dr. Charles WU
31. DATE FILED (Month, Day, Year)
DEC 1 3 1990



permit, Pages 1, 2, 3 should

use as the burial-transit

funeral director, page 5 should be detached for

filled in by the fion, or removal.

223

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. HEGIT HAR'S SIGNATURE

Julia Davidson-Randelle

FRANK PERETTI, MD

31. DATE FILED (Month, Day, Year)
DEC 1

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | 7 | 7 |
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| | 후 | ラ号 |
| |) THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 4-10 uns |) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in if filed within 72 hours after death with the State Dept. of Health and Mertal Hyglene prior to burial, cremation, or re |
| | E | 王 은 |
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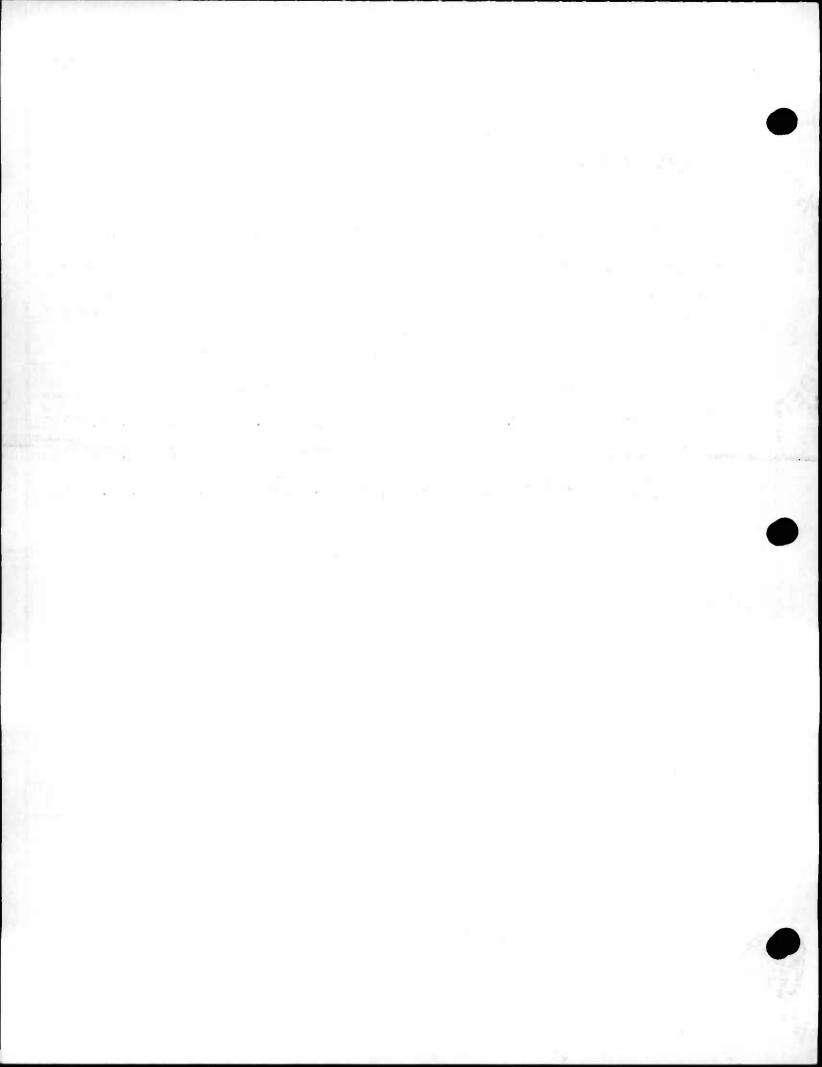
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) Huggins 12-10-90 8:19PM Harry 7. DATE OF BIRTH (Month, Day, Year) 09-30-49 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 214-86-8779 1 M 2 F Maryland 41 YAS. 9a. FACILITY NAME (If not institution, give street and number) 9b, CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Baltimore City DIRECTOR 1705 N. Register Street none RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 10a STATE 10b. COUNTY Baltimore City YES 2 NO Maryland none 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 1705 Register Street 21213 United States 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, atc. FORCES? 1 YES 2 If yes, specify Cuben, Mexican, Puerto Ric 1 YES ZIXNO Specify: 1 Never Married 2 Married Specify: BY 3 Widowed 4 Olvorced Negroid 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co during most of working H intary/Secondary (0-12) College (1-4 or 5+) Disabled COMPL 10th grade none none once. 16. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) Matthew Huggins Annie Lawrence Ħ notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Matthew Huggins Jr. Cedarcroft Rd. Baltimore 21239 .Md. must be 20a, METHOD OF DISPOSITION
1 A Buriel 2 Cremetion 3 A Re 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20c. LOCATION — City or Town, State Woodlawn Cemetery Baltimore. 4 Donation 5 Other (Specify) Maryland 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
SCRUGGS Funeral Home medical examiner 1412 E. Preston St, Balto, Md. 21213 23. PART I. Enter the diseases, or complications that the deeth. Do not enter the mode of dying, such as cerdiec or reapiretory errest, shock, or heart feilure. List only one ceuse on each line. interval Between Onset end Desth **IMMEDIATE CAUSE (Finel** the disease or condition resulting in death) Pneumonia event. DUE TO (OR AS A CONSEQUENCE OF): Chronic alcoholism traumatic CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST In Jury, 24a. WAS AN AUTOPSY PERFORMED? PART ii. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part i. 24b. WERE AUTOPSY FINDINGS MEDICAL AMAILABLE PRIOR TO COMPLETION OF CAUSE shows any YES 2 NO ®XVES 2 □ NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item OTHER: ng Home Residence 8 - Other (Specify) XXYES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 🗌 Nurs -0 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 28b. TIME OF marked, XXX Natural 5 Pending M 1 YES 2 NO ВҰ Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Sulcide 69 ETED. 8 Could not be determined 4 Homicide 28 Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. COMPL IMPORTANT: If XXXDEDICAL EXAMINER; On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(e) and manner se stated. 296 STONATURE AND TITLE OF CERTIFIES 29d, DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE 12-11-90 OCME 2

111 Penn Street, Baltimore, MD 21201



DHMH-16 Rev 1/89

VC



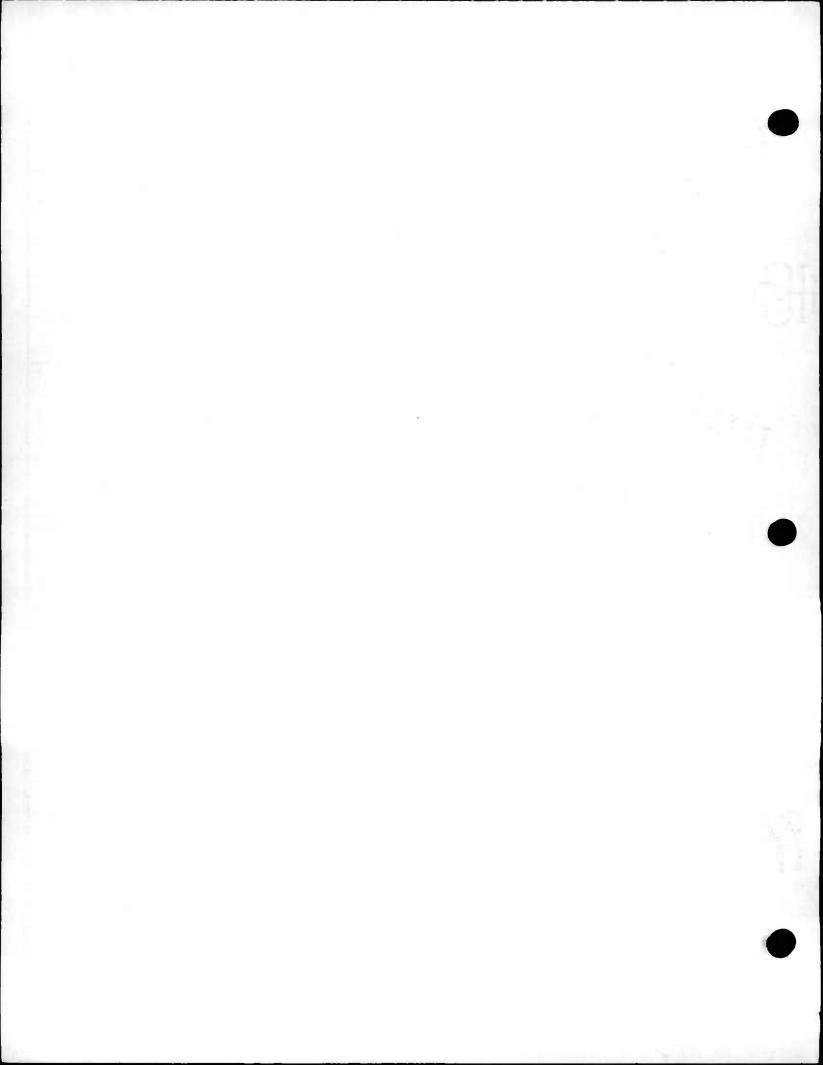
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| | retained b | 5 should | notified a |
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| | The law re | te has bee | om 23 sh |
| | SICIAN: | certificat | d, or ite |
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| | NETTEN | ACTUR. | em 28 k |
| CION I | Stores | 素を | INTER IN |
| No. | TO THE MISSION BY PUSICIAN. The law requires that the death certificate be executed within 2 Jours after death. Page 6 may be retained by the hos | TO I Compared to the confidence have been signed by the attention physician and completely filed in by the funeral director, page 5 should be detached to the compared to the | be that when I have been with the State Dept. Or receipt any mental hypere provide units, we managed, or saminer must be notified at once. IMPORTANT: If I hem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | | | |

| | , Middle, Lest) Johr |) (J | OHN H Hur | UNDLE | y Jr. | ₹.) | | | 2. DATE OF | 6-90 ⁴ | Y | YEAR | 3. TIME OF DEATH 6:09PM | | | | | | | |
|---|--|--|--|-------------------|--------------------------------------|---------------------------------------|---------------------------|-------------|-----------------------------------|--|--|-----------------|---|--|--|--|--|--|--|--|
| 4. SOCIAL SECURITY NUM | BER | 5. SEX | 8. AGE (In yrs | s. last birthday) | # UNDER | DAYS | IF UNDE | R 24 HRS. | 7. DATE OF (Month, D | | | 8. BIRTI | HPLACE (State or Foreign | | | | | | | |
| 224-34-2 | | | 58 | YRS. | | | | | | 22- | | | VA. | | | | | | | |
| 9a. FACILITY NAME (If not i | | and the same of th | | | | | | ION OF D | | | 9c. COU | NTY OF E | HTAB | | | | | | | |
| 625 N. Car | | on Avenue | 2 | | | Ват | LIIO | re C | Lty | | L | | | | | | | | | |
| 10m. STATE | 10b. COUNT | Υ | | 10c. Cl | ry, town o | R LOCAT | ION | | | | | | 10d. INSIDE CITY | | | | | | | |
| MD | | | | ВА | LTIM | 10R | Ε. (| CITY | | | | | 1 XX ES 2 NO | | | | | | | |
| 10e. STREET AND NUMBER | | | | | | | ZIP COD | | | | 19g. CIT | IZEN OF | WHAT COUNTRY? | | | | | | | |
| 625 CARR | OLLTO | N AVE. | | | | | 212 | 217 | | | | US | A | | | | | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDED | YES 2 | ARMED NO | 13. V | NAS DEC | ENDENT | OF HISPAI | NIC ORIGIN? (S in, Puerto Rica | Specify Yes | or No- | 14. RAC Blac | E American Indian, ik, White, etc. | | | | | | | |
| 1 Never Married 2 X | | | MAR OR DATES | | 1 | ☐ YES | 2 X X 10 | Specif | y: | , | | Spec | | | | | | | | |
| | CEDENT'S EDU | ICATION | ARM | DECEDENT | I ISUM OC | CUBATI | NA . | | 18h Ki | ND OF BUS | IMESS/IMI | DUSTRY | BLACK | | | | | | | |
| | ly highest grade | | | | work done d | | | ing | Tou. To | 10 01 000 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | 2001111 | | | | | | | | |
| 4 t h | 0-12) | Conege (1-4 or 5 | *' | UNEN | 1PLOY | ED | | | ì | | | | | | | | | | | |
| 17. FATHER'S NAME (First, | Aiddle, Last) | | | | | | 18. MOT | HER'S NA | ME (First, Mide | tle, Maiden | Surname) | | | | | | | | | |
| JOHN HU | NDLEY | SR. | | | | | I | ORO | THY | | | | | | | | | | | |
| 19a, INFORMANT'S NAME | | N-Miles | | 19b. MAILIN | G ADDRESS | (Street i | ind Numbe | or or Rural | Route Number, | City or Tow | n, Stete, Zip | Code) | | | | | | | | |
| HATTIE HUNDLEY 1731 FREEDOM WAY-BALTIMORE, MD. 212 | | | | | | | | | | 21213 | | | | | | | | | | |
| 20a. METHOD OF DISPOSITION 1. C. Burlel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VET. CEM OWINGS MILLS, MD. | | | | | | | | | | | | | | | | | | | | |
| 4 Donation 5 Othe | r (Specify) | | _ GA | RRISC | | | | | | OM | INGS | MI | LLS, MD. | | | | | | | |
| 21. SIGNATURE OF FUNER | AL BENVICE LI | CHARGE | | | 22. 1 | NAME A | ND ADDR | ESS OF FA | CILITY | | | | | | | | | | | |
| IN | De la | Jua | | | WN | 1.C | , MA | ARCH | F.H. | 11 | 01 E | . N | ORTH AVE | | | | | | | |
| 23. PART I. Enter the ahock, or IMMEDIATE CAUSE (F disease or condition resulting in death) | heart fallure. | a. Arter | use on each | na. | cardi | | | | | | ratory er | reat, | Approximate interval Betwee Onset and Dea | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | | | | | | | | | |
| PART II. Other signific | ant condition | ne contributing t | o death but i | not resulting | in the un | deriyin | g cause | given in | Part I. 2 | ta. WAS AN | | 24 | b. WERE AUTOPSY FINDING | | | | | | | |
| | | | | | | | | | | YES : | | | COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| | in a second seco | | | | | | | | XIX YES 2 NO | | | | | | | | | | | |
| | | HEAD ONLY | | | | | | | | | | | | | | | | | | |
| | | | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED | TO MEDICAL | | | | T | | | | | EXAMINER? HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | |
| | TO MEDICAL | HOSPITAL: | ☐ ER/Outpatie | ont 3 🗆 DOA | | Rt: | | | | Specify) | | | | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? 7 YAYES 2 NO 27. MANNER OF DEATH | | 1 Inpatient 2 | | 28b. T | 4 🗆 Nun | R: sing Hor 28c. IN | | | | | INJURY O | CCURED | | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? 7(1) YES 2 \(\text{I NO} \) 27. MANNER OF DEATH | TO MEDICAL Pending | 1 Inpatient 2 28a. DATE C | F INJURY Day, Year) | 28b. Ti | 4 - Num | R: sing Hor 28c. IN W | JURY AT DRIC? YES 2 | Residence | 8 Other (S | NBE HOW | | | | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? YAYES 2 NO 27. MANNER OF DEATH XX Natural 5 2 Accident | Pending | 1 Inpatient 2 28a. DATE C (Month, | F INJURY | 28b. Ti | 4 - Num | R: sing Hor 28c. IN W | JURY AT DRIC? YES 2 | Residence | 8 Other (3 | NBE HOW | and Numbe | | Route Number, | | | | | | | |
| 25. WAS CASE REFERRED EXAMINER? YAYES 2 NO 27. MANNER OF DEATH XX Natural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only | Pending investigation Could not be determined | 28a. DATE C (Month, 28e. PLACE building | F INJURY Day, Year) OF INJURY g, etc. (Specify) of my knowledg | At home, farm | 4 □ Nun ME OF NJURY M , street, fact | R: sing Hor 28c. IN W 1 lory, office | JURY AT DRK? YES 2 | NO NO | 8 Other (3 | ON (Street Town, State) | and Numbe | or or Rura | Route Number, | | | | | | | |

32. REGISTRAR'S SIGNATURE.

31. DATE FILED (Month, Day, Year)

PFC 1 3 1990



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| P.O. | |
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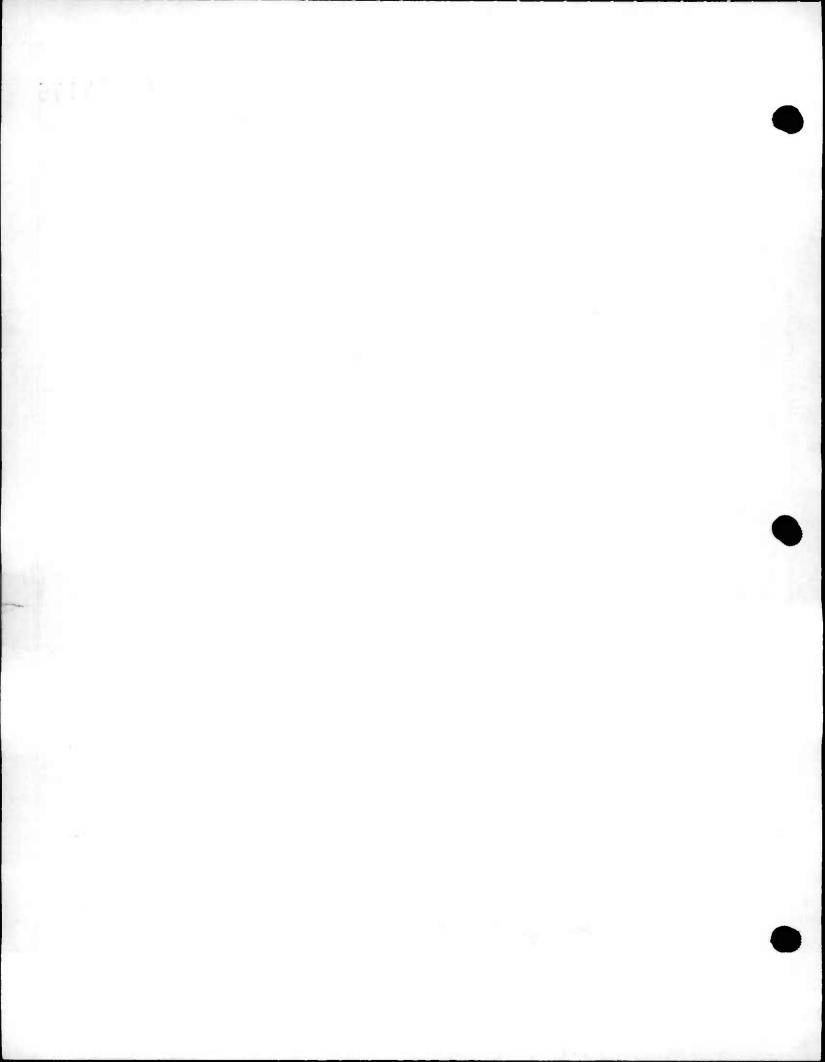
II. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a function of the death certificate has been signed by the attending physician.

LINECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Item 26 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | for STATE REGISTRAR | STATE OF MARYLAND / DE CER | EPARTMENT OF | | MENTAL HYGIENE REG. NO. | 90 34171 | | | | | |
|------------------|--|---|---|---|--|---|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH DAY | Y YEAR 3. TIME OF DEATH | | | | | |
| | IRENE VIRGIN | | | | 12-09-9 | | | | | | |
| | | SEX 6. AGE (In yrs. last birt | thday) IF UNDER 1 YEAR YRS. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Veer) 4-10-13 8. BIRTHPLACE (State or Forek | | | | | | |
| | 215-32-9490 9a. FACILITY NAME (If not institution, give street | | | OR LOCATION OF DE | | 9c. GOUNTY OF DEATH | | | | | |
| TOR | BALTIMORE COUNTS | GENERAL | BALT | IMORE M | ſD, | DAG imake | | | | | |
| EC | 10a. STATE 10b. COUNTY | 10 | Oc. CITY, TOWN OR LOC | ATION | | 10d. INSIDE CITY | | | | | |
| ä | MD BALTI | IMORE | RANDALI | STOWN | | 1 WES 2 THO | | | | | |
| RAL | 3520 CABOT RD. | | | or. ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? USA | | | | | |
| FUNERAL DIRECTOR | | . WAS DECEDENT EVER IN U.S. ARMED | | | IC ORIGIN? (Specify Yes | Yea or No.— 14. RACE — American Indian. | | | | | |
| BY | 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, | specify Cuban, Mexican S 2 NO Specify | n, Puerto Ricen, etc.) | Black, White, etc. Specify: BLACK | | | | | |
| 9 | 15. DECEDENT'S EDUCATE (Specify only highest grade com | | DENT'S USUAL OCCUPAT | ISUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY ork done during most of working | | | | | | | |
| COMPLETED | Elementary/Secondary (0-12) C | College (1-4 or 5+) | MEMAKER | | | | | | | | |
| CON | 17. FATHER'S NAME (First, Middle, Last) | | | | ME (First, Middle, Maiden : H CARTER | Surname) | | | | | |
| BE | COLEY MORGAN | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) SARAH MILLS | | | | Oute Number, City or Town | IMORE, MD.21215 | | | | | |
| | 20a. METHOD OF DISPOSITION 1X Puriel 2 Cremation 3 Removal | 20b, PLACE OF E | DISPOSITION (Name of a | emetery, cremetory or | 20c. LOC | CATION — City or Town, State | | | | | |
| | 4 Donation 5 Other (Specify) | KING | MEMORIA | | | LTIMORE, MD. | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | Tak . | 0.000 | C. MARCH | E17070 | 01 E. NORTH AVE. | | | | | |
| | | plications that caused the death tonly one cause on each line. DUE TO (OR AS A CONSEQUE) | | | | interval Between | | | | | |
| N | Samurablelly Hat conditions b. | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| FI | CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| ER | resulting in deeth) LAST | | | | | | | | | | |
| CAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? AMILABLE PRIOR TO | | | | | | | | | | |
| | DIODETES Mell/705 1 YES 2 INTO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | | |
| PHYSICIAN: MED | 1 _ YES 2 _ NO | | | | | | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATN (Check only one) | | | | | | | | | | |
| SIC | EXAMINER? | R/Outpatient 3 🗆 | OTHER: | oma 5 🗆 Raaldenca | | | | | | | |
| PHY | 27. MANNER OF DEATN | 28s. DATE OF INJURY (Month, Day, Year) | 8b. TIME OF 28c. 1 | NJURY AT VORK? | 28d. DEŞCRIBE NOW II | NJURY OCCURED | | | | | |
| BY | 1 Natural 5 Pending 2 Accident Investigation | 28a DI ACE OF IN HIDY At home | | YES 2 NO | | | | | | | |
| TED | 3 Suicide a Could not be 4 Homicide determined | building, stc. (Specify) | JURY — At home, farm, atreet, factory, office (Specify) | | | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLET | Torroom oray | N: To the best of my knowledge, death On the basis of exemination and/or inve | | | | iner sa stated, d due to the cause(s) and manner sa stated, | | | | | |
| | 296, SIGNATURE AND TUTLE OF CERTIFIER | , | 1001 | 29c. LICENSE NUI | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| O BE | MINIM | Mmon & ml | aggut | MAR B | 11171 | 1/19/90 | | | | | |
| 10 | 30. NAME AND ADDRESS OF BERSON WHO C | OMPLEYED CAUSE OF DEATH (ITEM 27 | 7) (Type, Print) | 5557 | Boron | NATLIPE | | | | | |
| | 31. DATE FILDEC 1 3 1990 | 32. PEGISTRAPIS SIGNATURE JUNE DANIGON-ROM | delle | | CAO | NEWALE ZON | | | | | |

DHMH-16 Rev 1/89



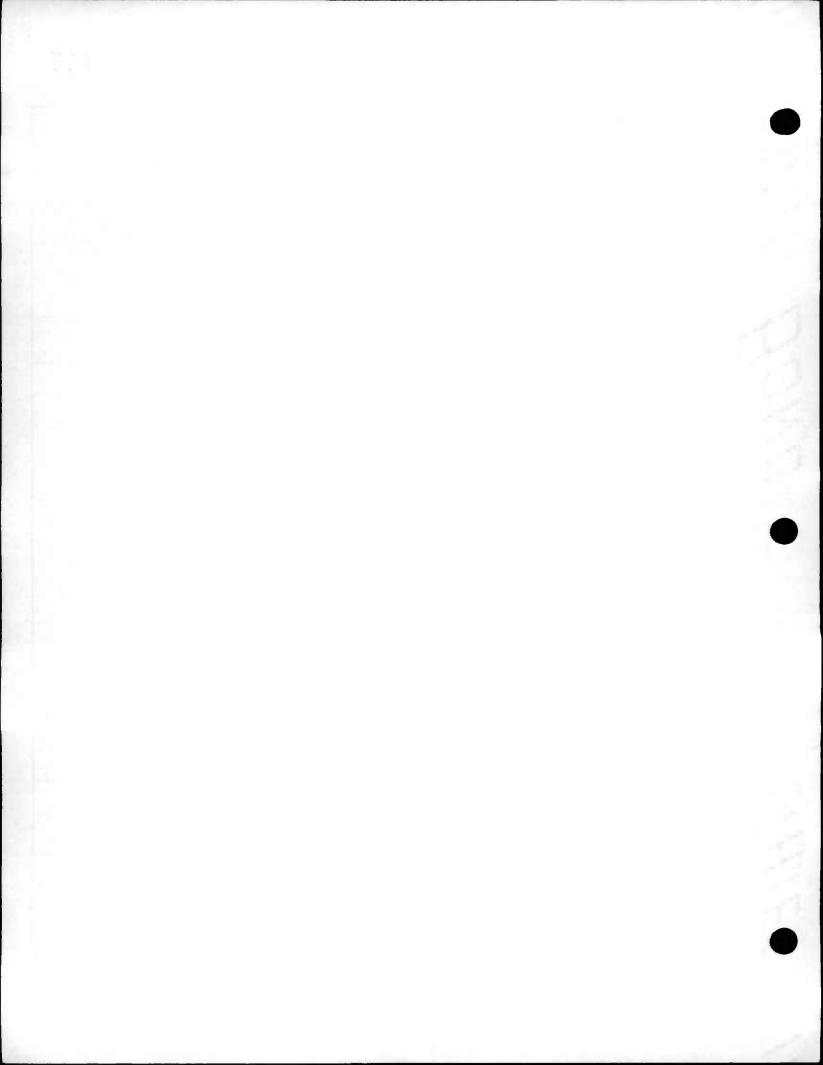
BALTIMORE, MARYLAND 21203-3146

ISION OF VITAL RECORDS, P.O. BOX 13146,

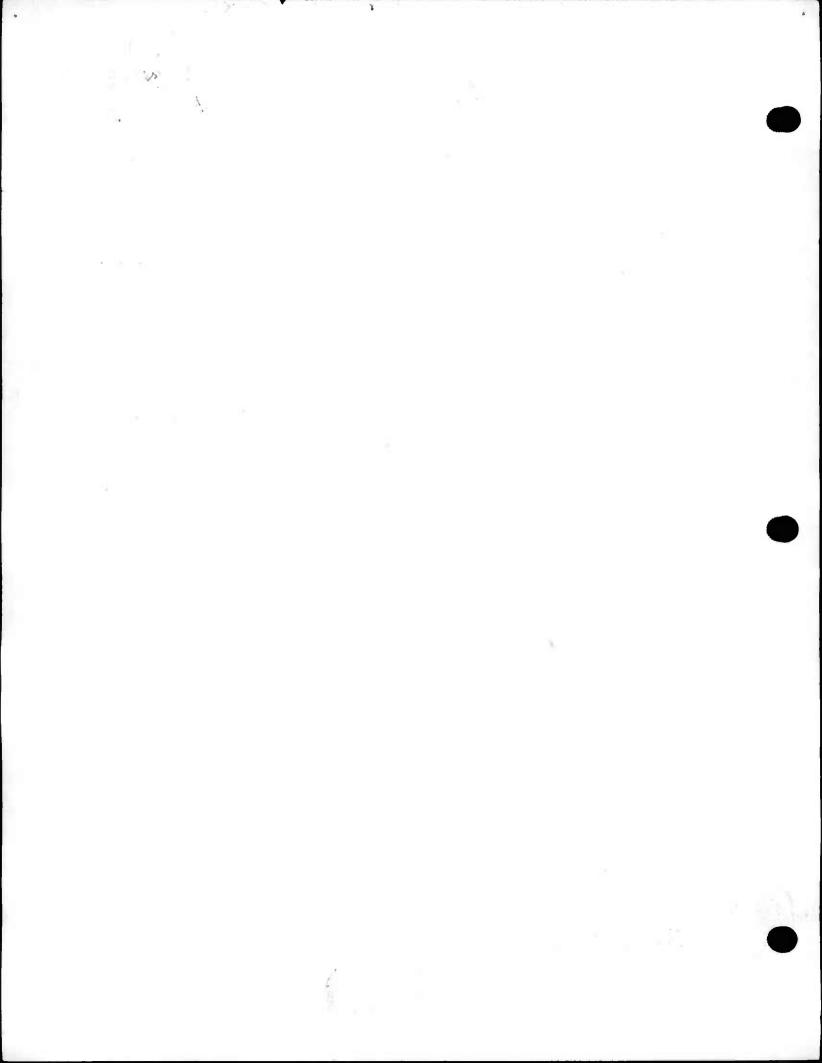
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| | TO THE MINIOR OF MANAGEMYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the | TO THE FIGHTH STORY, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be de | be not recommended to be the State Dept. of Health and Merital Hygiene prior to buntal, cremation, or removal. | IMPORTANT: If them 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on |
| | | | | |

| | ExTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit, Pages 1, 3 method for use as the burlal-transit permit permit. | |
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| MITENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | firector, page 5 show | r must be notifie |
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| requires that the d | been signed by the | shows any iniu |
| HYSICIAN: The law | his certificate has with the State Dept | ted or item 23 |
| H ATTENDING P | after death y | m 28 le man |

| FOR STATE REGISTRAR | STATE OF M | CEF | RITIFICA | TE OF | JEAIH | | REG. NO | | | |
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| 1. OECEDENT'S NAME (First, Middle, Last) | | | JOK: | NSON | | 2. DATE MONT | | | YEAR 90 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 217-32-7800 | | 6. AGE (In yrs. lest bi | YRS. IF U | | IF UNDER 24 HRS. HOURS MIN. | (Mont) | OF BIRTH h, Day, Year) | 189 | 6. BIRTH Countr | PLACE (State or Foreign y) |
| 9a. FACILITY NAME (If not institution, give | | | 9b. | CITY, TOWN OR | LOCATION OF OR | | - / / | | TY OF D | EATH |
| Liberty Medic | cal Cent | er | | Balti | more | | | | | |
| 10a. STATE 10b. COUNT | | | | WN OR LOCATIO | | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland 100. STREET AND NUMBER | | | Bal | timore | ZIP CODE | | | 10g, CITE | ZEN OF V | 1 X YES 2 NO |
| 3836 Rolandv | iew Ave. | | | | 21215 | | | U. | s. | Α. |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | T EVER IN U.S. ARME YES 2 NO AR OR DATES | | If yes, spec | NDENT OF HISPAN Hy Cuban, Mexica C NO Specify | n, Puerto | | n or No | 14. RACE Black Speci | - American Indian, k, Whita, atc. fy: Black |
| 15. DECEDENT'S EDI (Specify only highest grad | UCATION le completed) | 16a. DECE (Give | EDENT'S USW | AL OCCUPATION done during most red.) | of working | 168 | . KINO OF BU | SINESS/IND | USTRY | DIACK |
| Elementary/Secondary (0-12) | College (1-4 or 5+ | , | omemal | | | | Hous | orri f | | |
| 17. FATHER'S NAME (First, Middle, Last) | | 110 | memai | | 16. MOTHER'S NA | ME (First, | | | E | |
| Aquillie Lee | | | | | Eva S | | | | | |
| 19a. INFORMANT'S NAME (Type/Print) Esther Champ: | ion | | | | d Number or Rural I | | | | | MD 2121 |
| 20a, METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Rec | | | F DISPOSITION | | IEW AV | /e. | 20c. LC | CATION - | City or To | wn, Stata |
| 4 Donation 5 Other (Specify) | | | | emoria | 1 Park | | Ва | 1tin | ore | County, |
| 21. SIGNATURE OF FUNERAL SERVICE L | JCENSEE | | | 22. NAME AND | ADDRESS OF FA | CILITY | Nutte | r Fu | iner | al Homes |
| 23. PART I. Enter the diseases, or shock, or heert fellure | complications that | t caused the deat se on each line. | th. Do not e | 2501 _Balti | Gwynns more, | Fa Mar | 11s P | arkw 21 | 216 | Approximata interval Between |
| 23. PART I. Enter the diseases, or shock, or heert fellure IMMEDIATE CAUSE (Final disease or condition resulting in death) | s | SEPSIS (OR AS A CONSEQU | JENCE OF): | 2501 Balti enter the mode | Gwynns more, | Fa Mar | 11s P | arkw 21 | 216 | Approximata interval Between |
| 23. PART I. Enter the diseases, or shock, or heert fellure IMMEDIATE CAUSE (Final disease or condition | s | SEPSIS (OR AS A CONSEQUED OR AS A CONSEQUED) | DENCE OF): | 2501 Balti | Gwynns more, e of dying, suc | Fa Mar | 11s F yland dlec or reep | arkw 21 | 216 | Approximata interval Between |
| 23. PART I. Enter the diseases, or shock, or heert fellure shock, or heert fellure immediate cause or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | S. OUE TO DUE TO C. DUE TO d. C. C. Ontributing to | SEPSIS (OR AS A CONSEQUE PN WEM (OR AS A CONSEQUE LIBST VE (OR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE | JENCE OF): JENCE OF): JENCE OF): REPORT OF INTERPRETATION OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFIC | 2501 Balti Balti Enter the mode | Gwynns more, e of dying, suc | L'H | 11s F yland dlec or reep | AUTOPSY | 7a y . 216 | Approximata interval Betwee Onset and Decorate and Decora |
| 23. PART I. Enter the diseases, or shock, or heert feilure industrial disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other significant conditions are under the condition of the condition | S. OUE TO DUE TO C. DUE TO d. C. C. Ontributing to | SEPSIS (OR AS A CONSEQUE PN WEM (OR AS A CONSEQUE LIBST VE (OR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE | JENCE OF): JENCE OF): JENCE OF): REPORT OF INTERPRETATION OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFICIAL OFFIC | 2501 Balti Balti Enter the mode | Gwynns more, e of dying, suc | LM LM Part I. | RE 244. WAS APPERFO 1 USS | AUTOPSY | 7a y . 216 | Approximata Interval Betwe Onset and Dec Dec Dec Onset and Dec Dec Dec Dec Dec Dec Dec |
| 23. PART I. Enter the diseases, or shock, or heert fellure shock, or heert fellure in the shock of the shock | b. DUE TO c. CON (DUE TO d. CON (DOBE CONTIDUTING TO | SEPSIS (OR AS A CONSEQUE PN WEM (OR AS A CONSEQUE LIBST VE (OR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE LOR AS A CONSEQUE | JENCE OF): JENCE OF): JENCE OF): RESULTING In the | 2501 Balti Balti meter the mode | Gwynns more, e of dying, suc | LM LM Part I. | RE 24e. WAS AI PERFO 1 YES | AUTOPSY | 7a y . 216 | Approximata interval Betwee Onset and Dei On |
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| 0) | | REGISTRAR 1. DECEDENT'S NAME (First | Middle, Last) | | | CENTIF | ICATE U | F DEA | T | 2. DATE OF | REG. NO. | | 3 1 | IME OF OEATH |
| | ì | JEANETTE | | NSON | | | | | | MONTH | DAY | | EAR Q | 45 a.m. м |
| | | 4. SOCIAL SECURITY NUM | BER | 5. SEX | 8. AGE (In yrs | . last birthday) | IF UNDER 1 YEAR | R IF UNDER | | NOVEM 7. DATE OF | BIRTH | 4 199 | BIRTHPLA | E (State or Foreign |
| | | 216-36-834 | .3 | 1 🗆 M 2 💢 F | 80 | YRS. | MONTHS DAY | B HOURS | MIN. | 8-21 | "-"1"91 | .0 | Nuntry) | arolina |
| 3 should | | 9a. FACILITY NAME (If not in | nstitution, give str | eet and number) | | | 9b. CITY, TOW | N OR LOCAT | ION OF DEAT | тн | | 9c. COUNTY | OF DEATH | |
| 89 | 8 | THE JOHNS | HOPKI | NS HOSPI | TAL | | BALTIM | ORE CI | TTV | | | BALT | IMORE | CITY |
| , , | ᇤ | RESIDENCE OF DEC | 10b. COUNTY | | | 10e. Cl | TY, TOWN OR LO | | | | | | 100 | . INSIDE CITY |
| Page | DIRECTOR | MD. | | | | | Baltim | | | | | | 3 | LIMITS? |
| 3-3146 ending physician. as the bunal-transit permit, Pages 1, 2, | | 10e. STREET AND NUMBER | | | | | 1 | 101. ZIP COD | DE | | | 10g. CITIZEI | OF WHAT | COUNTRY? |
| nsit p | FUNERAL | 1834 N. | Broady | vav | | | | | | | | U | .S.A | 1. |
| siclan ial-tra | 3 | 11. MARITAL STATUS | | 12. WAS DECEDEN | NT EVER IN U.S. | ARMED | | | OF HISPANIC | | | or No- 14 | RACE — / | American Indian, |
| 146 g phy e bur | BY F | 1 Never Married 2 3 Widowed 4 Divo | | | WAR OR DATES | | | ES 2 TO NO | en, Mexican, Specify: | Puerso Mica | m, auc., | - 1 | Specify: | Black |
| 21203-3146 Ital or attending phys I for use as the buri | 9 | | EDENT'S EDUC | ATION | 164 | DECEDENTY | B USUAL OCCUP | ATION | | 185.10 | NO OF BUSI | NESS/INDUS | TOV | |
| or ath | | | ly highest grade o | completed) | | (Give kind of | work done during ise retired.) | | ing | 100. K | ND OF BOSI | NESS/INDOS | INI | |
| Spital o | <u>ब</u> | Elementary/Secondary (| P12) | College (1-4 or 5 | *) | Doi | nestic | | | | | | | |
| LAND by the hospit be detached at once. | COMPLET | 17. FATHER'S NAME (First, A | | | | | | 18. MOT | THER'S NAME | E (First, Midd | tle, Maiden S | iumame) | | |
| YL/ | BE | Robert 1 | McCul1 | .oh | | | | Ma | aggie | e Le | eper | | | |
| MARYLAND e retained by the hosp s 5 should be detache notified at once. | 9 | 19a. INFORMANT'S NAME (| Type/Print) | | | 196 MAILIN | 9 Marb | et and Numbe | a I I | RD Number | City or Town, | State, Zip Co | ide) | |
| BALTIMORE, MARYLAND 21203-3146 ler death. Page 6 may be retained by the hospital or attending physician, the funeral director, page 5 should be detached for use as the burial-tran yal. | | Bernard | | on | | | | | | | Dail | 0.,111 | | |
| | | 29. METHOD OF DISPOSIT | on 3 🗆 Ramo | oval from Stale 20b. PLACE OF DISPOSITION (Name of complex), crematory other place) MT.ZION CEMET | | | | | eter: | ery 20c. LOCATION — City or Town, Slete Baltimore | | | | |
| MO direc | Ì | 4 Dorffittoy 5 Other | | ENSEE O | 0 / | 7 | 22. NAME | AND ADDRE | ESS OF FACI | LITY | р. | aiti | 1010 | |
| ALTIM death. Pag tuneral dil 1. | | 7 | - | 11 | 200 | / | Red | ld Fu | nera | 1 Se | rvic | e 172 | 21-2 | Monroe |
| 66 . 9 76 - 1 | _ | 1) lun | well | X.K | a del | | | | | | | | | |
| In the | 1 | 23 PART I. Enter the d ahock, or h | liseases, or c leart fallure. I | omplications the | at caused the use on aach | death. Do lina. | not anter the | mode of dy | ylng, auch | as cardia | or reapir | atory arres | t, | Approximate Interval Between |
| ion iii | 1 | IMMEDIATE CAUSE (F) | nal | <i>-</i> | -1. | \ . | 1 0 . 1 | | | | | | | Onset and Death |
| thin at the | | resulting in death) | → , | OUE TO(OR AS A CONSEQUENCE OF): | | | | | | | | | | hour |
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| | 2 | Sequentially list conditions if any, leading to imme | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| BOX ficate be physician ne prior t | 8 | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Nesses of Inlun) | | | | | | | | | | | | |
| O. BO certificate ding physi tyglene pri | | | | <u> </u> | | |) | |) | | | | | |
| O O DE P | F | CAUSE (Disease or Injustrational Initiated events | ury | DUE TO | O (OR AS A CO | NSEOUENCE (| , | |) | | | | | - |
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| E Me d | AL CERTIFICATION | CAUSE (Disease or Injustrational Initiated events | ST C | 1 | | | OF): | ying causa |) givan in P | Part I. 2 | la. WAS AN | 4500 | | RE AUTOPSY FINDINGS |
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| OF VITAL RECORDS, PHYSICIAN: The law requires that the d this certificate has been signed by the with the State Dept. of Health and Mei ricked, or Item 23 shows any Injur | 7 | CAUSE (Disease or Injuthat Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 2 Accident | ant conditions | HOSPITAL: 1 □ Inpatient 2 28e. DATE Of (Month, i.e.) | ER/Outpatier | not resulting | OTHER: 4 Nursing I ME OF JURY M 1 | I. PLACE OF INJURY AT WORK? | DEATH (Chec | ok only one) Other (S 28d. DESCF | PERFORI | MED? MED? MED? | CO OF 1 [| ILABLE PRIOR TO WPLETION OF CAUSE DEATH? |
| OF VITAL RECORDS, PHYSICIAN: The law requires that the d this certificate has been signed by the with the State Dept. of Health and Mei ricked, or Item 23 shows any Injur | BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injute Initiated events resulting in death) LAS PART II. Other eignific 25. Was CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Neturel 5 2 Accident | ant conditions TO MEDICAL | HOSPITAL: 1 Inpatient 2 28e. DATE OI (Month, I | ER/Outpatier | not resulting | OF): In the underly OTHER: 4 Mursing I ME OF 28c. UJURY | I. PLACE OF INJURY AT WORK? | DEATH (Chec | ck only one) Other (S 28d. DESCP | PERFORI | MED? | CO OF 1 [| ILABLE PRIOR TO WPLETION OF CAUSE DEATH? |
| ISION OF VITAL RECORDS, UTENDING PHYSICIAN: The law requires that the deficies. After this certificate has been signed by the after death with the State Dept. of Health and Met. 28 is marked, or flem 23 shows any Injur | BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutat Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide | ant conditions TO MEDICAL Pending Investigation Could not be detarmined | HOSPITAL: 1 Inpatient 2 28e. DATE building | Den/Outpetter FINJURY Dey, Year) OF INJURY — A | not resulting | OTHER: 4 Nursing I ME OF 28c. JURY M 1 streel, factory, c | i. PLACE OF Injury AT WORK? YES 2 | DEATH (Chec | 1 Description of the control of the | PERFORI YES 2 Specify) HIBE HOW IN ON (Street a. | MED? NO JURY OCCUP AND AND AND AND AND AND AND AND AND AND | AMP CO OF 1 [| ILABLE PRIOR TO WPLETION OF CAUSE DEATH? |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the rours after death with the State Dept. of Health and Meitem 28 is marked, or them 23 shows any Injur | BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutat Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only) 1 CER | ant conditions TO MEDICAL Pending investigation Could not be detarmined | HOSPITAL: 1 Inpatient 2 28e. DATE (Month, I | ER/Outpatier F INJURY Dey, Year) OF INJURY — A J, etc. (Specify) | nt 3 DOA 28b. Ti | OTHER: 4 Nursing I ME OF 28c. JURY M 1 , streel, factory, c | I. PLACE OF Home 5 F INJURY AT WORK? YES 2 | DEATH (Chec | Disk only one) 3 Other (\$28d, DESCR | PERFORI YES 2. Specify) ON (Street a fown, Stee) | MED? NO NO NO NO NUMBER OF | AMACO CO OF 1 [| ILABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the rours after death with the State Dept. of Health and Meitem 28 is marked, or them 23 shows any Injur | COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injithat Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only 0ne) 2 MEC | ant conditions TO MEDICAL Pending Investigation Could not be detarmined TOTIFYING PHYSIC | HOSPITAL: 1 Inpetient 2 28e. DATE Of (Month, Inselted in Special Clans: To the best of R: On the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: The special Clans is the special Clans in the special Clans is the special Clans in the special Clans in the special Clans is the special Clans in the special Clans in the special Clans is the special Clans in th | ER/Outpatier F INJURY Dey, Year) OF INJURY — A J, etc. (Specify) | nt 3 DOA 28b. Ti | OTHER: 4 Nursing I ME OF 28c. JURY M 1 , streel, factory, c | D. PLACE OF INJURY AT WORK? YES 2 office data and place n, death occur, death occur, | DEATH (Checker) Residence 8 NO NO Dece, and due to | Other (S 28d, DESCF 28t, LOCATI City or to the cause lime, data and | PERFORI YES 2. Specify) ON (Street a fown, Stee) | MED? NO NO NUMBER OF THE STATE OF THE STA | AMP CO OF 1 [| ILABLE PRIOR TO WPLETION OF CAUSE DEATH? YES 2 NO Number, |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the rours after death with the State Dept. of Health and Meitem 28 is marked, or them 23 shows any Injur | BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutat Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only) 1 CER | ant conditions TO MEDICAL Pending Investigation Could not be detarmined TOTIFYING PHYSIC | HOSPITAL: 1 Inpetient 2 28e. DATE Of (Month, Inselted in Special Clans: To the best of R: On the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: To the best of the special Clans: The special Clans is the special Clans in the special Clans is the special Clans in the special Clans in the special Clans is the special Clans in the special Clans in the special Clans is the special Clans in th | ER/Outpatier F INJURY Dey, Year) OF INJURY — A J, etc. (Specify) | nt 3 DOA 28b. Ti | OTHER: 4 Nursing I ME OF 28c. JURY M 1 , streel, factory, c | D. PLACE OF INJURY AT WORK? YES 2 office data and place n, death occur, death occur, | DEATH (Chec | Other (S 28d, DESCF City or to the cause lime, data and BER | PERFORI YES 2 Specify) IIBE HOW IN ON (Street a. forwn, Stete) (a) and manual diplace, and | MED? NO NO NUMBER OF THE STATE OF THE STA | RED Rural Route Couse(s) an | ILABLE PRIOR TO WPLETION OF CAUSE DEATH? YES 2 NO Number, d manner as stated. |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the hours after death with the State Dept. of Health and Metitem 28 is marked, or them 23 shows any Injur | COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutation Initiated events resulting in death) LAS PART II. Other signific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 Homicide 29a. CERTIFIER (Check only one) 2 MEC | ant conditions TO MEDICAL Pending Investigation Could not be detarmined TITIFYING PHYSIC DICAL EXAMINES E OF GERTIFIER | HOSPITAL: 1 Inpatient 2 28e. DATE Of Month, I 28e. PLACE (building) | ER/Outpetler FINJURY Dey, Year) OF INJURY — in the control of the | nt 3 DOA 28b. Ti N Al home, farm. | OTHER: 4 Nursing I MC OF Aurora 1 1 streel, factory, of the time | I. PLACE OF Home 5 F IRJURY AT WORK? YES 2 Office | DEATH (Chec | Other (S 28d, DESCF City or the ceuse lime, deta an BER 3 \$ 2 | PERFORI YES 2 Specify) IIBE HOW IN ON (Street a flown, Stete) (a) and manual place, and | MED? NO NUTRY OCCUP Number or Number or Number of due to the d | RED Rural Route Couse(s) an | ILABLE PRIOR TO WPLETION OF CAUSE DEATH? YES 2 NO Number, |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the rours after death with the State Dept. of Health and Meitem 28 is marked, or them 23 shows any Injur | BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutation Initiated events resulting in death) LASPART II. Other eignific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) 2 MEC 29b. SIGNATURE AND TITL 30. NAME AND ADDRESS C | ant conditions TO MEDICAL Pending Investigation Could not be detarmined TITIFYING PHYSIC DICAL EXAMINES E OF GERTIFIER | HOSPITAL: 1 Inpatient 2 28e. DATE (Month, I) 28e. PLACE (building) CIAN: To the best of (c) | Deprovement of the control of the co | nt 3 DOA 28b. Ti III Al home, farm. e, death occur d/or investigat | OF): In the underly OTHER: 4 Nursing I ME OF 28c. JURY M 1 streel, factory, commend at the time, comm | I. PLACE OF INJURY AT WORK? YES 2 Office dete and place 35e Lie | DEATH (Chec | Other (S 28d, DESCF City or the ceuse lime, deta an BER 3 \$ 2 | PERFORI YES 2 Specify) IIBE HOW IN ON (Street a flown, Stete) (a) and manual place, and | MED? NO NUTRY OCCUP Number or Number or Number of due to the d | RED Rural Route Couse(s) an | ILABLE PRIOR TO WPLETION OF CAUSE DEATH? YES 2 NO Number, d manner as stated. |
| DIVISION OF VITAL RECORDS, OR ATTENDING PHYSICIAN: The law requires that the d DIRECTOR: After this certificate has been signed by the rours after death with the State Dept. of Health and Meitem 28 is marked, or them 23 shows any Injur | BE COMPLETED BY PHYSICIAN: MEDICAL | CAUSE (Disease or Injutation Initiated events resulting in death) LASPART II. Other eignific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only one) 2 MEC 29b. SIGNATURE AND TITL 30. NAME AND ADDRESS C | ant conditions TO MEDICAL Pending Investigation Could not be determined TITIFYING PHYSIC E OF SERTIFIER OF PERSON WHO S S C | HOSPITAL: 1 Inpatient 2 28e. DATE (Month, I) 28e. PLACE (building) CIAN: To the best of (c) | Deprovement of the control of the co | nt 3 DOA 28b. Ti III Al home, farm. e, death occur d/or investigat | OTHER: 4 Nursing I MC OF Aurora 1 1 streel, factory, of the time | I. PLACE OF INJURY AT WORK? YES 2 Office dete and place 35e Lie | DEATH (Chec | Other (S 28d, DESCF City or the ceuse lime, deta an BER 3 \$ 2 | PERFORI YES 2 Specify) IIBE HOW IN ON (Street a flown, Stete) (a) and manual place, and | MED? NO NUTRY OCCUP Number or Number or Number of due to the d | RED Rural Route Couse(s) an | ILABLE PRIOR TO WPLETION OF CAUSE DEATH? YES 2 NO Number, d manner as stated. |



| has been Dept. of 1 23 sho | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shous be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified. |
|----------------------------------|--|
| | TO THE HOSPITAL OR ALENDING PHYSICIAN: The law requires that the death certificate be executed within 24-cours are death. Tage 5 into the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shout be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified. |

| | FOR S' | TATE OF MARYL | | | HEALTH AND I | MENTAL HYGIEN REG. NO | _ | 34179 |
|---------------|---|---|--|--------------------|---|--|-----------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) Richard M. | Johns | 00 | <u> </u> | . DEATH | 2. DATE OF DEATH MONTH D. | | 3. TIME OF DEATH OBYSAM |
| | 010 -0 1201 | (M2□F 5. | (In yrs. last birthday) YRS. | IF UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 35 P | ountry) aryland |
| TOR | 99. FACILITY NAME (If not institution, give street a St. Ances Hos RESIDENCE OF DECEDENT | spital | | Bal | imore | EATN | Ba! | Timore |
| DIRECTOR | 10e. STATE 10b. COUNTY 10e. STREET AND NUMBER | nore | | town on Lo | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 4655 Manord | ean Rd WAS DECEDENT EVER | N II S ADMED | | 21229 | NIC ORIGIN? (Specify Ye | J | J.S.A. RACE — American Indian, |
| BY | 1 Never Married 2 Married | FORCES? 1 TYES | 2 JNO | If yes, | specify Cuben, Mexico ES 2 NO Specif | n, Puerto Ricen, elc.) | | Black, White, etc. Specify: Black |
| COMPLETED | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp Elementary/Secondery (0-12) Co | N lieted) Hege (1-4 or 5+) | Ille. Do NOT us | ork done during | most of working | 18b. KIND OF BU | SINESS/INDUST | RY |
| BE COM | 17. FATNER'S NAME (First, Middle, Last) Luther Johnson | | | | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Leola Brown | 125- | | | | Route Number, City or Tov Balto., M | | 21239 |
| | 20e. METHOD OF DISPOSITION 1 Structure 2 Cremetton 3 Removal 4 Opticion 5 Other (Specify) | from Stale | b. PLACE OF DISPOS other place) ZiO1 | n Ceme | cemetery, crematory or | В. | eltimo | |
| | 21. BIOLOGICAL OF FUNERAL SERVICE LICENSE | Resid | | Rec | AND ADDRESS OF FA | | 1721- | 27 Monroe S |
| | A PART I. Enter the disesses, or compands, or heart failure. List IMMEDIATE CAUSE (Finel disesse or condition resulting in deeth) | Olications that cause only one cause on a | esch ilne. | | mode of dying, suc | th ee cerdisc or reep | iretory arreet, | Approximate interval Between Onset and Death |
| NO | Sequentially list conditions, | Dup Ves | A CONSEQUENCE OF | ntri | | 7 | | Empre |
| CERTIFICATION | If any, isading to immediets couse. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF | e du | ng feile | Ul | | 4 years |
| L CER | PART II. Other significant conditions co | entributing to dasth | but not resulting | n the underl | ying cause given in | Part i. 24a. WAS AI | N AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| MEDICA | _ Day of the | | | | | PERFO | | AMAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO |
| PHYSICIAN: | | OSPITAL: | testlent 3 🗆 DOA | OTHER: | . PLACE OF DEATH (C | VETTEL CAST | | |
| ву РНУ | | | | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28a. PLACE OF INJUP building, atc. (Sp | | street, factory, o | office | 281. LOCATION (Street City or Town, State | | Rural Route Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PNYSICIAN (MEDICAL EXAMINER: One) | • | | | | | | suse(e) and menner se stated. |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER MANUAL C LA LIMINA 30. NAME AND ADDRESS OF PERSON WHO CO | b Mh | | | 29c. LICENSE NU | MBER | | GNED (Month, Day, Year) - 6 - 9 0 |



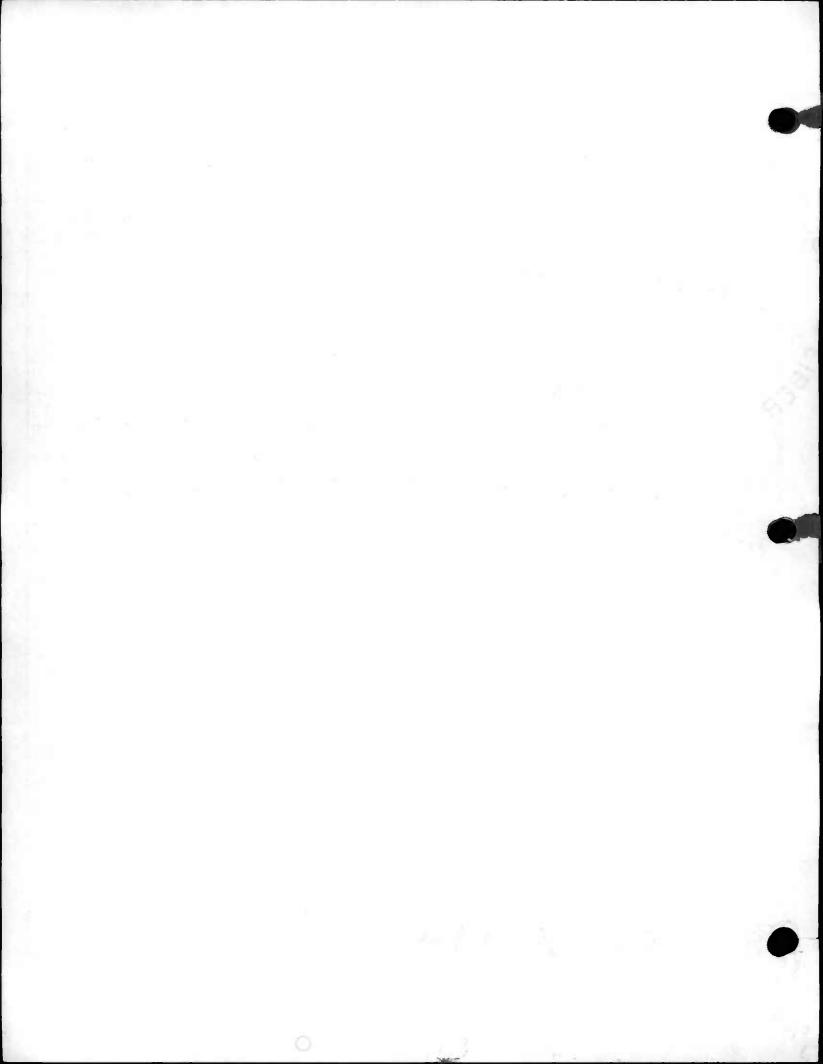
31. DATE FILED (Month, Day, 1990)

34180 90

| ı | • | FOR STATE REGISTRAR |
|---|---|---------------------------|
| | | |

| | 1 - STATE REGISTRAR | OIATE OF MI | CE | RTIF | ICATE (| F DEATH | | REG. NO. | | | | |
|-------------------------|--|---|-------------------------|-----------------------|--------------------------------|---|---|----------------------|---|--------------------|-------------------------------|------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | OF DEATH | v v | EAR : | 3. TIME OF DEATH | |
| | Kevin B. | | | Jones | | | 12-9-90 | | | | 4:35PM | М |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yrs. in | | | | | | 7, DATE OF BIRTH (Month, Day, Year) | | | BIRTHP Country) | LACE (State or Foreign | |
| | 219-76-1721 | 1 XM 2 - F | 32 | YRS. | MONTHS DA | YS HOURS MIN. | | /58 | | | YLAND | |
| | 9a. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TO | WN OR LOCATION OF DI | EATH | 1.0 | 9c. COUNTY | OF DE | ATH | |
| DIRECTOR | University Hospi | tal | | | Ba | altimore Ci | ity | i | | _ | | |
| E I | 10e. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN OR L | OCATION | | | | | 10d. INSIDE CITY LIMITS? | |
| ā | MARYLAND | | | | BALTI | MORE CIT | Y | | | | YES 2 NO | |
| A | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | 10g. CITIZEN | | | HAT COUNTRY? | |
| E | 2104 BOYD STR | EET | | | | 21223 | | USA | | | | |
| COMPLETED BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT I FORCES? 1 I IF YES, GIVE WAS | YES 2 N | MED IO | If yo | DECENDENT OF HISPAL s, specify Cuban, Mexico YES 2 NO Specifi | n, Puerto F | | | | | |
| | 15. DECEDENT'S EDU | CATION | 16a. DE | CEDENT'S | USUAL OCCU | PATION | 16b. | KIND OF BU | SINESS/INDUS | TRY | | |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (GI | Do NOT u | work done duni se retired.) | ng most of working | | | | | | |
| 립 | 12th | , | FC | RK | TTFT | DRIVER | | | | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | AME (First, I | Middle, Malden | Surname) | | | |
| | BURNELL BURRE | r.t. | | | | HAZEL | JON | IES | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19t | . MAILIN | ADDRESS (S | reet and Number or Rural | | | n, State, Zip Co | ode) | | |
| 2 | STEPHEN JONES | | 3 | 412 | GLEN | AVENUE: | BAL | TO. I | MARYL. | AND | 21215 | |
| | 20e. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Rem | noval from State | 20b. PLACE other ple | OF DISPO | SITION (Name | of cemetery, crematory or | | 20c. LC | CATION — CIT | y or Tow | vn, State | |
| | 4 Donation 5 Other (Specify) | | WES | TER | | R_CEMETE | | CA' | PONSV | LLL | E, MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | 0.0 | ust | 4 | LER | OY O. DY USE OF FREE CONTROL | ETT | | | | | |
| | 23, PART I. Eiter the diseases, or | complications that | caused the de | ath, Do | | | | | | | Approximete | |
| | effock, or fleet failure. IMMEDIATE CAUSE (Fine) disease or condition resulting in desth) | . Multip | V | hot | | | | | | | Interval Betw Onset and De | |
| : MEDICAL CERTIFICATION | Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | OR AS A CONSEC | | | | | - | | | | |
| | PART II. Other algorificant condition | rasulting | In the unde | riying ceuse given in | Part f. | 24a. WAS AI PERFO | RMED? | | WERE AUTOPSY FINDII AMAILABLE PRIDRI TO COMPLETION OF CAUS OF DEATH? YES 2 NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | 7 | 26. PLACE OF DEATH (C | heck only o | ne) | | 1 | | _ |
| SIC | EXAMINER? | HOSPITAL: | PR/Outpatient 3 | □ DOA | OTHER: | Home 5 Residence | 6 T 000 | ar (Snanihi) | | _ | | |
| ¥ | 27. MANNER OF DEATH | 28s. DATE OF I | | , | | c. INJURY AT | - | | INJURY OCCU | RED | | _ |
| 4 | 1 Natural 5 Pending | (Month, Day | (Month, Day, Year) | | | INJURY WORK? | | | | | | |
| ВУ | 2 Accident Investigation 12-9-90 28e. PLACE OF INJURY — At h | | | - 1 1 1ES 2 XXV | | | Subject shot 281. Location (Street and Number or Rural Route Number, | | | | | |
| ED | Security of Could not be building, etc. (Specify) | | | | | | C/ty | City or Town, State) | | | | M |
| E | 29e. CERTIFIER | | Но | | | at the time, date and place, and due to the cause(e) and manner as stated. | | | | | , IVIL | |
| COMPLETED | (Check only | | | | | i, date end place, and du ilon, death occured at th | | | | | and manner so state | ud. |
| 8 | | | - Indiana in a language | varaya | my opi | | | - orna primori, s | | | | red. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | ER) -/. | | | | OCME | JMBER | | | | (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON W | When sten and | E OE DEATH #== | M on a | o Out-of | COME | | | 1 | 2-1 | 0-90 | |
| | A THE STATE OF THE | | C OF DEATH (ITE | an 21) (1)/) | | | | | | | | |
| | DONALD WRIGHT, M 31. DATE FILED (Month, One, Year) | | R'S SIGNATURE | | 111 P | enn Street | Bal | timore | MD 21 | 201 | | VC |
| | DEC 1 0 1000 | A ST. REGISTRAS | 20.2 | 00 | | | | | | | | |

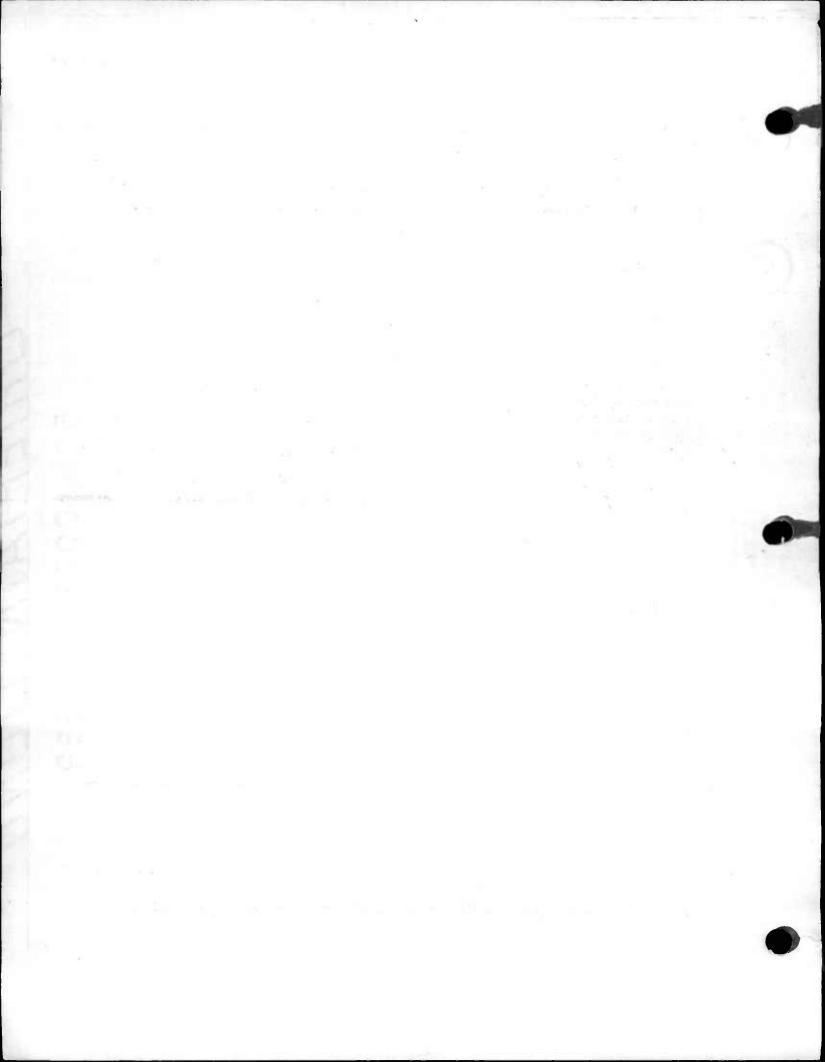




This was a such it is

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| DINGOUS O | | notified |
| 200 | | be |
| 10000 | | must |
| the comment in the second second in the second seco | l. | or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at one |
| and for the se | with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal | medicai |
| 2000 | dion, | the |
| in distance | J. crema | event. |
| - | to buria | matic |
| 30.00 | prior | trau |
| B | lygiene | othe |
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| 200 | Dept | 23 |
| וורמום | State | item. |
| 2000 | the | 0 |
| CHIS | with | rked |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | | YGIENE | 50 | U | 710. |
|--------------------|---|--|--|--|--|-------------------------------------|---------------|---------------------|--|--|
| = 1 | 1. DECEOENT'S NAME (First, Middle, Last) | | - / | | | 2. DATE OF | DEATN | | | IME OF DEATH |
| | The/ma | E. V | ohnson | | | MONTH . | - 9 DAY | TU YEAR | di | 145 A M |
| | 4. SOCIAL SECURITY NUMBER 222 - 10 - 42 11 | 5. SEX 6. AGE | (In yrs. lest birthday) 67 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF 1 (Month, De 4/2/1 | nv. Year) | Co | RTNPLAC untry) awaj | CE (State or Foreign |
| | 9e. FACILITY NAME (If not institution, give st | | | | OR LOCATION OF DE | EATH | | 9c. COUNTY O | | 340 |
| OR | PENINSULA GENER | RAL HOSPITAL | | SALIS | BURY, MD | | | WICOM | TCO | - |
| EG | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10e. CITY, | TOWN OR LOCAT | TON | | | | 10d | . INSIDE CITY |
| DIRECTOR | Delaware Suss | ex | Mil1 | sboro | | | | | 10 | LIMITS? |
| | 10e. STREET AND NUMBER | | | t01 | . ZIP CODE | | | 10g. CITIZEN O | F WHAT | COUNTRY? |
| ER | Rt. 4 Box 161 | | | 1 | 9966 | | | USA | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEOENT EVER FORCES? 1 TYES IF YES, GIVE WAR OR D | 2 100 | If yes, sp | ENDENT OF NISPAR ecify Cuben, Mexica 2X NO Specifi | n, Puerto Rica | | B S _i | lack, Wh pecify: | American Indian, lite, etc. |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S L (Give kind of w life. Do NOT use homemake | ork done during mo retired.) | ON st of working | 18b. KII | ND OF BUSE | NESS/INOUSTR | | |
| ON | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Midd | lle, Maiden S | umame) | | |
| BE C | Ephraim L. Marman | | | | Elizabe | th P. | Wrigh | nt | | |
| 10 8 | 190. INFORMANT'S NAME (Type/Print) | | | | nd Number or Rural | | | | | |
| F | Jean A. Norwood | | Rt. 4 | Box 170 | B, Mills | boro, | | | 9966 | |
| | 200, METHOD OF DISPOSITION 1) Burlel 2 Cremetion 3 Remo | ovat from State | b. PLACE OF DISPOSI other place) | | | | | sboro, | | |
| | 4 Donation 5 Other (Specify) | | ndian Mis | | metery | OII ITY | LITTI | SDOLO, | Del | Laware |
| | Melver T | - Valsa | 0 | | n Funera | | , Mil | .1sboro | , De | elaware |
| | 23. PART I. Enter the diseases, or cahock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | e. Acute | ed the desth. Do not esch line. | emia | de of dylng, euc | h se cardiac | or respire | ntory arrest, | | Approximate interval Between Onset and Death 3 mos - |
| NOI | Sequentially list conditions, fit smy, leading to immediate Due to (or as a consequence of): | | | | | | | | | |
| CAT | cause. Enter UNDERLYING CAUSE (Disease or injury | c. | | | | | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF |): | | | | | | |
| | BARY II Other claudieurs condition | | | are useries | | | | | | |
| PHYSICIAN: MEDICAL | PERFORMEO? 1 YES 2 NO | | | | | | | COL | RE AUTOPSY FINDINGS ILABLE PRIOR TO MPLETION DF CAUSE DEATH? YES 2 NO | |
| MA | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PI | ACE OF DEATH (Ch | eck only one) | | | | |
| SIC | EXAMINER? | HOSPITAL: | | OTHER: | e 5 Residence | 8 Other (S | neclfy) | | | |
| | 27. MANNER OF DEATN 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | OF 28c. IN. | | | | JURY OCCURE |) | |
| TED BY | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, etc. (Spe | IY — At home, farm, si ecify) | home, farm, street, factory, office 28t. LOCATION (St. City or Yown, S. | | | | d Number or Ru | ral Route | Number, |
| COMPLETED | 0/10) 2 MEDICAL EXAMINE | CIAN: To the best of my know | | | | | | | se(s) sno | d manner es stated. |
| TO BE | 296. SIGNATURE AND TITCS OF CERTIFIES | U) | W | | Dali | 278 | | ≥ /2 | NED (Mo | nth, Day, Year) |
| | David E. Courl | MD. 145 | 5 E. G | Print) S | t. Sa. | lisbury | M. | 0218 | 0/ | |
| | DEC 1 3 1990 | 32. REGISTRAR'S SIGN | Pandell | | | | | | _ | |



BALTIMORE, MARYLAND 21203-3146

Pages 1, 2, 3 should

ON OF VITAL RECORDS, P.O. BOX 13146,

permit. use as the burial-transit nours after death, Page 6 may be retained by the hospital or attending physician, filled in by the funeral director, page 5 should be detached for on, or removal. te notified pe examiner must the medical n and completely fille to burial, cremation, DATE ONG PHYSICIAN; The law requires that the death certificate be executed within event, traumatic signed by the attending physician Health and Mental Hygiene prior to other 6 In un. any shows a been s certificate has been the State Dept. of the Term 23 si 28 is marked, this c After t after DOURS Item TO THE PUTER TO THE PUTER De filed within 72 ho

BE

2

FRANK PERETTI , MD

a Davidson-Randage

90 34182 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 12-10-90 12:20PM Alexander Jones Patrick 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 🔐 M 2 🔲 F 11/23/1945 214-44-0799 Maryland 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 20000 Haines Avenue -in water Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY LIMITS? Ellicott City 1 TYES 2 X NO Maryland Howard FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 21043 S. A. 3590 Mount Ida Drive 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, White, etc. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yae or No-If yes, specify Cuban, Mexican, Puerto Ri
1 YES 2 NO Specify: 1 Never Married 2 X Married Specify: BY 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade co (Give kind of work done during life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) High School Landscaper 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Washington Ollie Jones 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 21043 Ellicott City, MD 3590 Mt. Ida Dr. Melba Jones 20a. METHOD OF DISPOSITION
1 \(\tilde{\Omega} \) Burlai 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) Removal from State
4 \(\tilde{\Omega} \) Onnation 5 \(\tilde{\Omega} \) Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, Stala Catonsville, MD Western Star Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, 2501 Gwynns Falls Parkway Herber Maryland Baltimore, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, **Approximate** ahock, or heart fellure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final disease or condition resulting in death) DROWNING DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other aignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a, WAS AN AUTOPSY WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AWAILABLE PRIOR TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE: Y YES 2 NO COMPLETION OF CAUSE CHRONIC ALCOHOLISM XX YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatiant 2 | ER/Outpatient 3 | DOA OTHER: XX YES 2 | NO 4 Nursing Home 5 Residence 8 Pether (Specify) Scene 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 27. MANNER OF DEATH 28d. DEŞCRIBE HOW INJURY OCCURED 1 Natural 1 YES ZYNO UNKNOWN UKN. UNKNOWN BY 2 Accident 281. LOCATION (Street and Number or Rural Route Number,
PATAPS (Chote) RIVER, Baltimore, MD 3 Suicide Could not be COMPLETED RIVER 4 Homicide 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 XMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as attated. 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER

OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

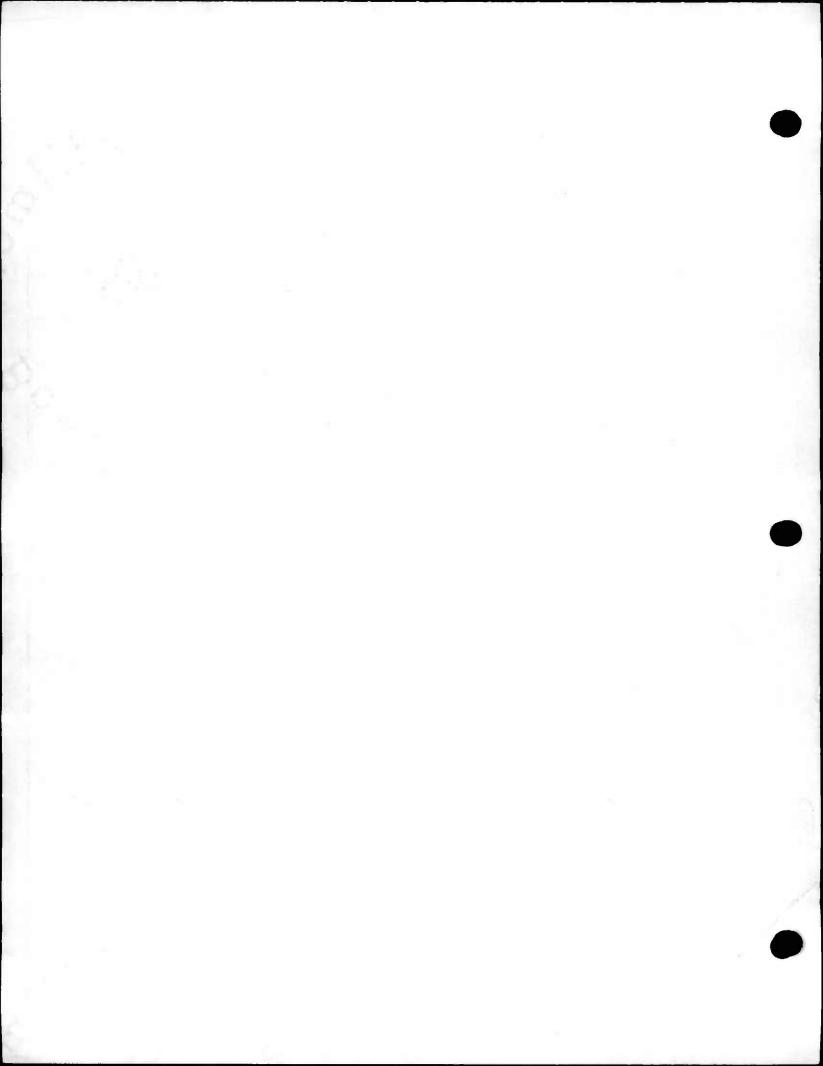
ETTI, MD 111 Penn Street, Baltimore, MD 21201

[No.] 32. BEGISTRAR'S SIGNATURE

OCME

DHMH-18 Rev 1/89

12-11-90



90 AR

9c. COUNTY OF DEATH

10g. CITIZEN OF WHAT COUNTRY?

USA

3. TIME OF DEATN

10d. INSIDE CITY

XXYES 2 NO

B. BIRTHPLACE (State or Foreign Maryland

25PM

2. DATE OF DEATH

7. DATE OF 5. (Month, Day, Year) 4

11

12 month

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

IF UNDER 1 YEAR IF UNDER 24 HRS.

6. AGE (In yrs. lest birthday)

YRS.

85

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Thomas J. Kelly

| 3 shoul | H. | 90. FACILITY NAME (If not institution, give street CHURCH HOSPI | | RATION | | MORE CIT | | 9c. COUNTY OF |
|---|---------------|--|--|---|---------------------|--|-------------------------|----------------------------|
| Pages 1, 2, | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 1% GT | LTIMORE | ONCITY | | |
| physician. burial-transit permit. Pages 1, | FUNERAL D | 100. STREET AND NUMBER EAST | AVENUE | | 101. | ZIP CODE 1224 | | 10g. CITIZEN O |
| | B | 11. MARITAL STATUS 1 Never Merried X2X XMerried 3 Widowed 4 Olvorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR | | | ENDENT OF HISPANIC Cooling Cuban, Mexican, Pu 2/1/2/NO Specify: | | or No— 14. R/ BI Sp |
| or aff | PLETED | 15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondary (0-12) | completed) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of v ille. Do NOT us | E.C. LO | N st of working | Exxon | INESS/INOUSTRY |
| \$ 8 € | BE COMPL | 17. FATHER'S NAME (First, Middle, Last) Thomas J. Kell | у | | | 18. MOTHER'S NAME (| Cramer | |
| y be retained age 5 should be notified | 5 | Margaret H. Ke | | 104 | N. East | Avenue/ | Balto. | MD 212 |
| rector, p | | 20e. METHOD OF DISPOSITION XIXBurlel 2 Cremation 3 Remo 4 Donation 5 Other (Specify) | val from Stata | Hot Piace of Dispos | deemer | | Ва | cation — chy or altimor |
| _ a a | | 21. SIGNATURE OF FUNERAL SERVICE LICE | Macs | S V | Morar | n-Ashton E. Balti | Funeral | |
| certificate be executed within consultation and ding physician and completely filled in by hygiene prior to burial, cremation, or remove other traumatic event, the medical | CERTIFICATION | 23. PART). Enter the diseases, or coahock, or heart feliure. LimMEDIATE CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in daeth) LAST | OUE TO (OR AS | each line. | <i>D (A C</i> n: | | | |
| requires that the deen signed by the of Health and Mer | MEDICAL | PART II. Other significent conditions | contributing to death | but not resulting | in the underlying | g ceuse given in Par | t I. 24a. WAS AN PERFOF | RMED? |
| N: The ficate h State (| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | utpatient 3 DOA | OTHER: | ACE OF OEATN (Check | | |
| U 40 . E | ВУ Р | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined | 26e. OATE OF INJUR' (Month, Day, Year, 28e. PLACE OF INJUI building, etc. (S) | PY — At home, ferm, | E OF 28c. INJ | URY AT 28 PRK? YES 2 NO | d. DESCRIBE HOW I | and Number or Ru |
| THE HOSPITAL OR ATTENDING THE FUNERAL DIRECTOR: After filed within 72 hours after death PORTANT: If item 28 is ma | COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PNYSK | CIAN: To the best of my kno | | | | | |
| TO THE HOSP! TO THE FUNER be filed within IMPORTANT: | TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | Vorzen | ni 1 | Defend | Di73 | 322 | ≥ /2 |
| | | 30. NAME AND ADDRESS OF PERSON WHO DR. NAZEMI, M 31. DATE FILED (Month, Day, Year) | | | DWAY BA | ALTIMORE | MD 212 | 31 |
| | | DEC 1 3 1990 | gulie Devidson | Handes | | | | |

90 34183

14. RACE — American Indien, Black, White, atc. Specify: white Avenue/Balto. MD 21224 Baltimore, MD Ashton Funeral Home, Inc. Baltimore St/Balto. MD 21224 Approximate intervai Between Onset and Death 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) occured at the time, date end place, and due to the cause(e) end menner ee stated. 29d. DATE SIGNEO (Month, Day, Year)

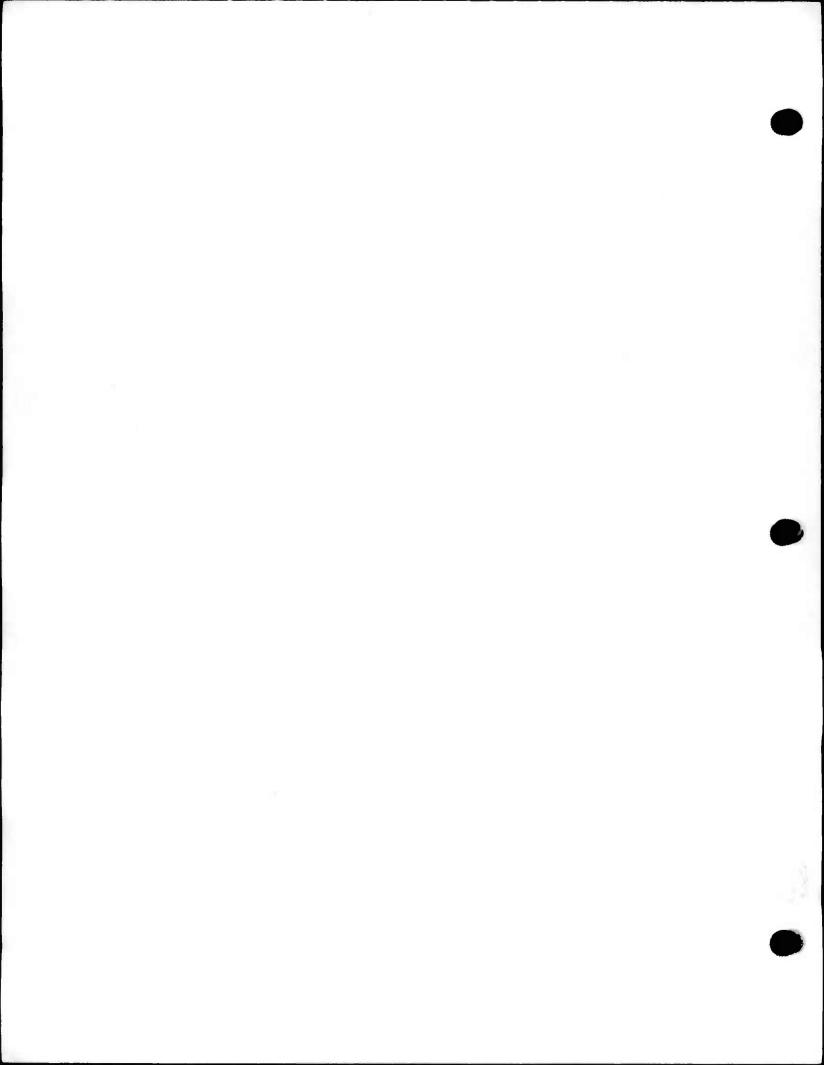
TO BE COMPLETED BY FUNERAL DIRECTOR

| DALIIMORE, MARTLAND | ACTION OF ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 frours after death. Page 6 may be retained by the host | ALTHAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache meneral powers after death with the State Dept. of Health and Memfal Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
| | 4 hours a | illed in by | e medic |
| 40, | ted within 2 | NOTE THE CHAIL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 second to build, cremation, or removal. | event, th |
| 2 | be execu | cian and for to bun | raumatic |
| . 0 | ertificate | ing physique pr | other t |
| Z. | feath c | attendi | ry, or |
| Ę, | at the | by the | y Inju |
| DIVISION OF VITAL RECORDS, P.O. BOA 13149, | equires th | en signed of Health | hows an |
| ļ | WE SW | has be Dept. | 1 23 \$ |
| - | AN: Th | ifficate e State | r Iten |
| 5 | HYSICI | his cer with th | ked, o |
| 2 | DING P | After t | mar. |
| 2 | ATTEN | CTOR: | 28 18 |
| 5 | IL OR | L DIRE | f Item |
| | | MIN 7 | NATE II |
| 小の世 | を発生を | See See See See See See See See See See | MPORTA |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

90 34184 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF CATE OF | | MENTAL HYGIEN | | 34184 |
|---|--|--|------------------------------------|--|-----------------------------|---|---------------------------|--|
| | DECEDENT'S NAME (First, Middle, Last) Woodrow Wilson Landes | S | | | | 2. DATE OF DEATH DO DECEMBER 10 | | 3. TIME OF DEATH |
| | | 7.0 | (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. B | HRTHPLACE (State or Foreign |
| | 219-07-9727 90. FACILITY NAME (If not institution, give stre- | 1 XM 2 F 74 | YRS. | | OR LOCATION OF DE | | 9c. COUNTY (| /irginia |
| | Meridian Nursing Home | | | Brookla | | | | cimore |
| I | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCA | NOIT | | | 10d. INSIDE CITY LIMITS? |
| ۱ | Maryland | | | Baltimo | | | | 1 X YES 2 NO |
| ì | 10e. STREET AND NUMBER | | | 1 | 21234 | | U.S. | OF WHAT COUNTRY? Δ |
| ı | | 12. WAS DECEDENT EVER IN FORCES? 1 YES | N U.S. ARMED | | CENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | or No.— 14, I | RACE — American Indian, Black, White, etc. |
| | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | | S 2 X NO Specify | n, Puarto Rican, etc.) | | Specify: White |
| | 15. DECEDENT'S EDUCA (Specify only highest grade co | TION ompleted) | 16a. DECEDENT'S (Give kind of w | USUAL OCCUPAT rork done during n e retired.) | ION ost of working | 16b. KIND OF BU | SINESS/INDUST | RY |
| | 12 yr's | College (1-4 or 5+) | | Engine | | | | |
| | 17. FATHER'S NAME (First, Middle, Lest) Robert | Cleveland | Lande | es | 18. MOTHER'S NA | ME (First, Middle, Maiden | | Garver |
| | Mrs. Yolanda G. La | ndes | | ADDRESS (Street | | Route Number, City or Tow | n, State, Zip Cod | (9) |
| | 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Remov 4 Donetion 6 Other (Specify) | al from State (| DAK LAWN | Cem. | 12/12/90 | | cation – city i daewat | or Town, Stata |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | Paul L. Ha | rtsock, Jr | 22. NAME | ND ADDRESS OF FA | CILITY Baltimo | | |
| | Yaul I, He | utook on | | Leo | nard J. F | Ruck, Inc. | 5305 | Harford Rd. |
| | 23. PART I. Enter the diseases, or co- shock, or heart failure. Li | mplicationa that cause at only ona cause on a | d the death. Do n sch ilne. | ot antar tha m | oda of dying, auc | h as cardisc or resp | Iratory arreat, | interval Between |
| | IMMEDIATE CAUSE (Finsi disessa or condition resulting in death) | Carro | limo. | · Quan | nomer de | Ame | A D | Onest and Dasth |
| I | , | DUE TO (OR AS A | CONSEQUENCE OF |): | 0 - | 7 | | |
| | Sequantially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF |): | men | DISK | cuse | |
| | cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | OUE TO (OR AS / | CONSEQUENCE OF | n: | | | | |
| I | resulting in dasth) LAST | | | | | | | |
| | PART II. Other significant conditions | | | n)the underlyl | ng cauas given in | Part i. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS |
| | Car | dising | pat | ny | | PERFOI | | AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| | | | | | | _ | | 1 TES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | CACE OF DEATH (Ch | eck only one) | | |
| 1 | 1 DYES TUNO | HOSPITAL: 1 Inpatient 2 ER/Outp | | | me 5 🗆 Residence | | | |
| ı | 1 Natural 5 Pending | (Month, Des. Hear) | 25b. TIM | DBA N | UURY AT ORK? YES 2 NO | 28d. DESCRIBE HOW | NJURY OCCURE | 10 |
| ١ | 2 Accident investigation 3 Suicide 6 Could-not be 4 Humicide determined | 26e. PLACE OF INJURY building, etc. (Spec | r — At home, ferm, a city) | treet, factory, off | ce | 281, LOCATION (Street City or Rwin, State) | and Number or R | ural Route Numbec |
| | | AN: To the best of my know | | | | | | |
| ı | 2 MEDICAL EXAMINER: | On the basis of examination | n andidr investibutio | n, in my opinion, | | | | use(s) and manner as stated. |
| | SIN SIN | oros | MI | 7 | D2 450 | | P / | Z 1190 |
| | Alan M. Shorofsky MD | | | | MH | | | ,, |
| | Alan M./ Shorofsky MD 31. DATE FILED (Movin, Day, New) | 32. REGISTRAR'S SIGN | worth Drive | : IOWSOII, | PU. | | | |
| | DEC 1 2 1000 10. | k. 50. | | | | | | |
| | 1000 7000 | Andrew Market | 3/8- | | | | | DHMH-16 Rev 1/89 |



BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within the death. Page 6 may be retained by the hospital or attending physician | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trains, mer within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTAN: Hiem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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Nayne

1990 3

31. DATE FILED (Month, Day, Year)

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sierbaum

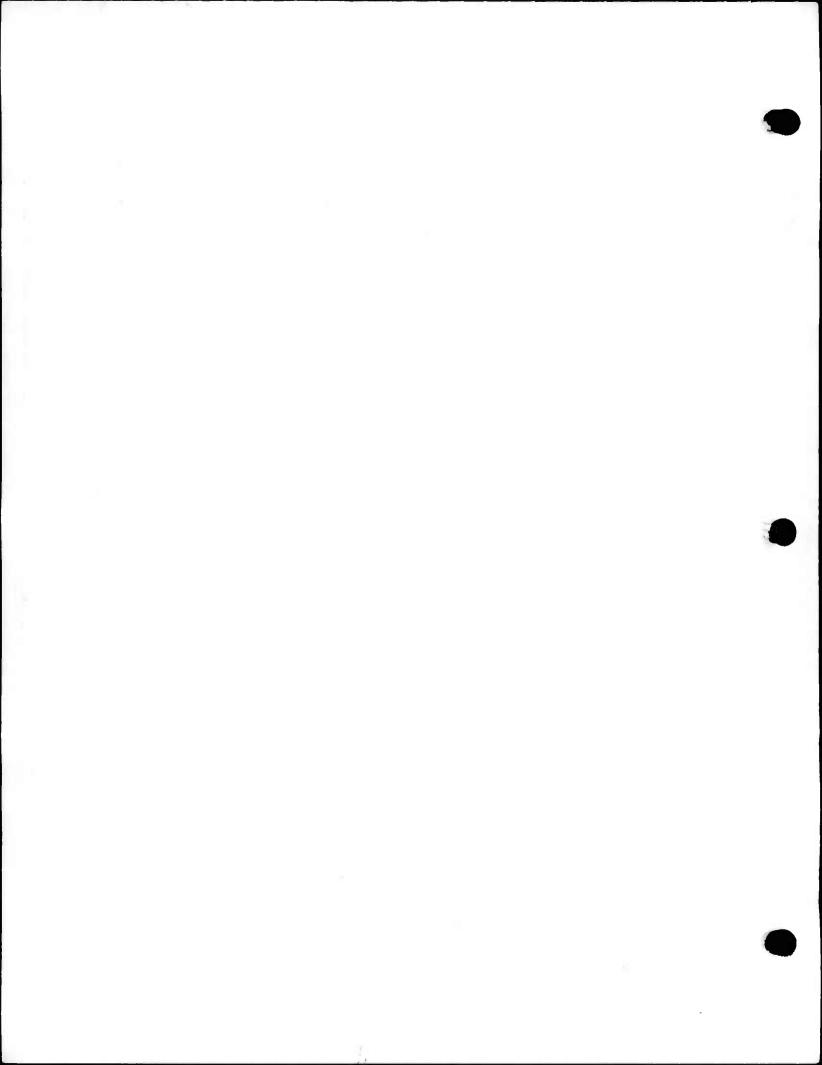
32. REGISTEAR'S SIGNATURES

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO Kenneth Graig McReaken かんんeaんeん 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH HTHOM Q DAY 90 YEAR ai 6 -7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 3 80 S 213-5 YRS. Maryland 11-15 9a. FACILITY NAME (If not institution, give stree 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIBECTOR Anne Arundel Medical Center Annapolis Anne Arundel RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland 1 X YES 2 NO Anne Arundel Crofton 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? FUNERAL 2131 Davidson Road 21114 USA 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yaa or No—
If yea, specify Cuban, Maxican, Puerto Rican, atc.)
1 YES 2 NO Specify: 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Married Specify: В 3 Widowed 4 Divorced White COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Kenneth Ralph McReaken Betty D. Wilkerson 8 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Boute Number City or Town, State, Zio Code) 2 Betty D. Beeler 15909 Bond Mill Road Laurel 20707 Md. 20s. METHOD OF DISPOSITION
1 | | Burisi | 2 | Cremation | 3 | Ramo
4 | Donation | Other (Specify) | 21. Biggstung of Juneaal Service Lice 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State Union Cemetery McConnellsburg Penna 22. NAME AND ADDRESS OF FACILITY Grove F.H. 141 West Main Street Hancock, Md 21750 23. PART i. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heert felius. Liet only one ceuse on each line. **Approximate** interval Between Onset end Death IMMEDIATE CAUSE (Final disesse or condition resulting in death) Huntingtons 1145 Chonea DUE TO (OR AS A GONSEQUENCE OF): MEDICAL CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? Huntingtone Chorea 1 X YES 2 NO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) EXAMINER? HOSPITAL:
1 Minpetiant 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO ng Home 5 - Residence & - Other (Specify) 4 🗆 Nur 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DEŞCRIBE HOW INJURY OCCURED 28b. TIME OF INJURY 19th Natural 1 YES 2 NO ВҰ 2 Accident investigation 28e. PLACE OF INJURY --- At home, farm, street, factory, offica building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined COMPLETED 4 🔲 Homicide CERTIFIER (Check only off)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piace, and due to the cause(a) and manner as stated. 29a. CERTIFIER 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE D12/6/90 Burbaum 33563

134 owensuille Rd

West River mo

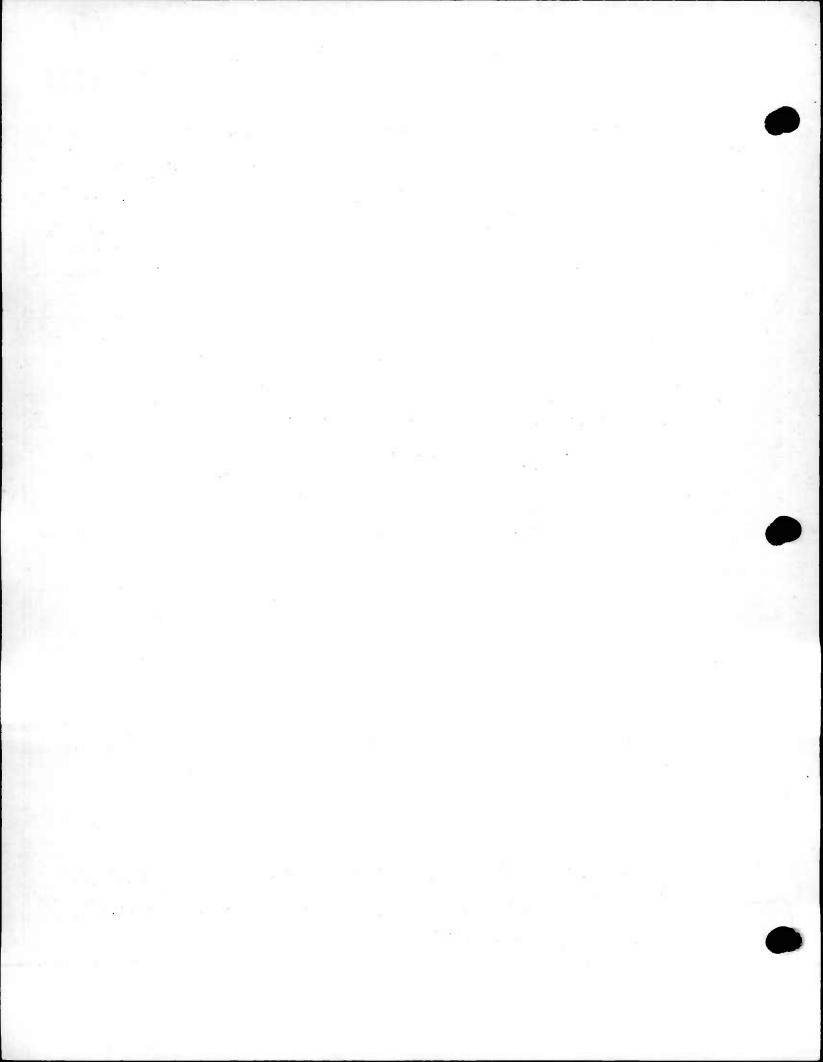


| 13146 |
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| BOX |
| P.O. |
| RECORDS, |
| JE VITAL |
| DIVISION |

| | 3 should | | |
|--|---|---|--|
| | 1, 2, | | |
| | Pages | | |
| LENDING PHYSICLAN: THE LAW PEQUIFES That the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital of attending physician. | TOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, | hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | INDOCTANT Hitem 28 is marked or item 23 shows any injury or other fraumatic event; the medical examiner must be notified at once |
| K A | RECTO | urs aft | m 28 |
| AL O | AL DIF | within 72 hours after (| H Hos |
| HOSPI | FUNER | within | TANT |
| # | 黑 | filed y | PANG |
| 2 | 2 | 8 | N |

90 34 186 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - FOR STATE REGISTRAR | STATE OF MARY! | | NT OF HEALTH AND | MENTAL HYGIEN | E 90 | 34186 | | |
|--|--|---|--|--|-------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Las KATHERINE | Ε | MICHAEL | | 2. DATE OF DEATH | 1990 | 3. TIME OF DEATH 8:20 P | | |
| 4. SOCIAL SECURITY NUMBER 212-09-2631 98. FACILITY NAME (If not institution, giv | 1 - M 2 - F 8 | 37 YRS. MONT | NDER 1 YEAR IF UNDER 24 HRS. HS DAYS HOURS MIN. CITY, TOWN OR LOCATION OF E | 7. DATE OF BIRTH (Month, Day, Year) March 20,1 | 903 M | aryland | | |
| Holly Hill Manor | | | Towson | EATH | sc. county | ltimore | | |
| 10e. STATE 10b. COUR | VTY | | vn on Location timore | | | 10d. INSIDE CITY LIMITS? 1 XYES 2 NO | | |
| 100. STREET AND NUMBER 5215 Anthony Ave | 3 | | 101. ZIP CODE 21206 | | 10g. CITIZEN | OF WHAT COUNTRY? Δ | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 NO | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 NO Speci | an, Puerto Rican, atc.) | or No- 14. | RACE — American Indian, Black, Whita, atc. Specify: White | | |
| 15. DECEDENT'S EI (Specify only highest gra Elementary/Secondary (0-12) | | | one during most of working ed.) | 16b. KIND OF BUS | SINESS/INDUST | | | |
| 10 17. FATHER'S NAME (First, Middle, Last) | | Homemaker | | OWN | Home | | | |
| John A. | Nut | :h | | nerine | , | Friskey | | |
| 19a. INFORMANT'S NAME (Type/Print) Katherine A. Ric | | 19b. MAILING ADD | Florence Rd. | Route Number, City or Tow | n, State, Zip Cod | 9) 15237 | | |
| 20a. METHOD OF DISPOSITION 157 Burlal 2 Cremation 3 Records Donation 5 Other (Specify) | emoval from State | b. PLACE OF DISPOSITION other place) | (Name of cemetery, crematory or | 20c. LO | CATION — City | or Town, Stata | | |
| IN HONAUGHE OF FUNERAL SERVICE | | ioly Redeem | 22. NAME AND ADDRESS OF F Leonard J. Ri 5305 Harford | ACILITY | ltimore Md : | | | |
| shock, or heart failure. List only one cause of each line. Interval Bel Onset and disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| thet initiated events resulting in death) LAST PART II. Other significent conditions. | d | A CONSEQUENCE OF): but not resulting in the | a underlying cause given li | 1 Part I. 24a. WAS AN PERFOR | RMED? | 24b. WERE AUTOPSY FINDIN AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (C | heck only one) | | | | |
| EXAMINER? | HOSPITAL: 1 Inpetient 2 ER/Out | | HER: Mursing Home 5 - Residence | 8 Other (Specify) | | | | |
| 27. MANNED OF DEATH 16 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW I | NJURY OCCURE | ED | | |
| 3 Suicide 8 Could not to datarmined | 28a. PLACE OF INJUR | Y — At home, farm, atreet, acity) | factory, offica | 261. LOCATION (Street City or Town, State) | | ural Route Number, | | |
| | YSICIAN: To the best of my know | | | | | use(a) and manner as stated. | | |
| 296. SUSTATURE AND TITLE OF CERTIF | | es . | - D-09 | | | GNED (Month, Day, Year) | | |
| 30. AME AND ADDRESS OF PERSON OF PER | WHO COMPLETED CAUSE OF D OLDON 32. REGISTRATE SIG Fully Davidson-Am | NEI/MI | 0-750/ | lorked | lov | vson md | | |



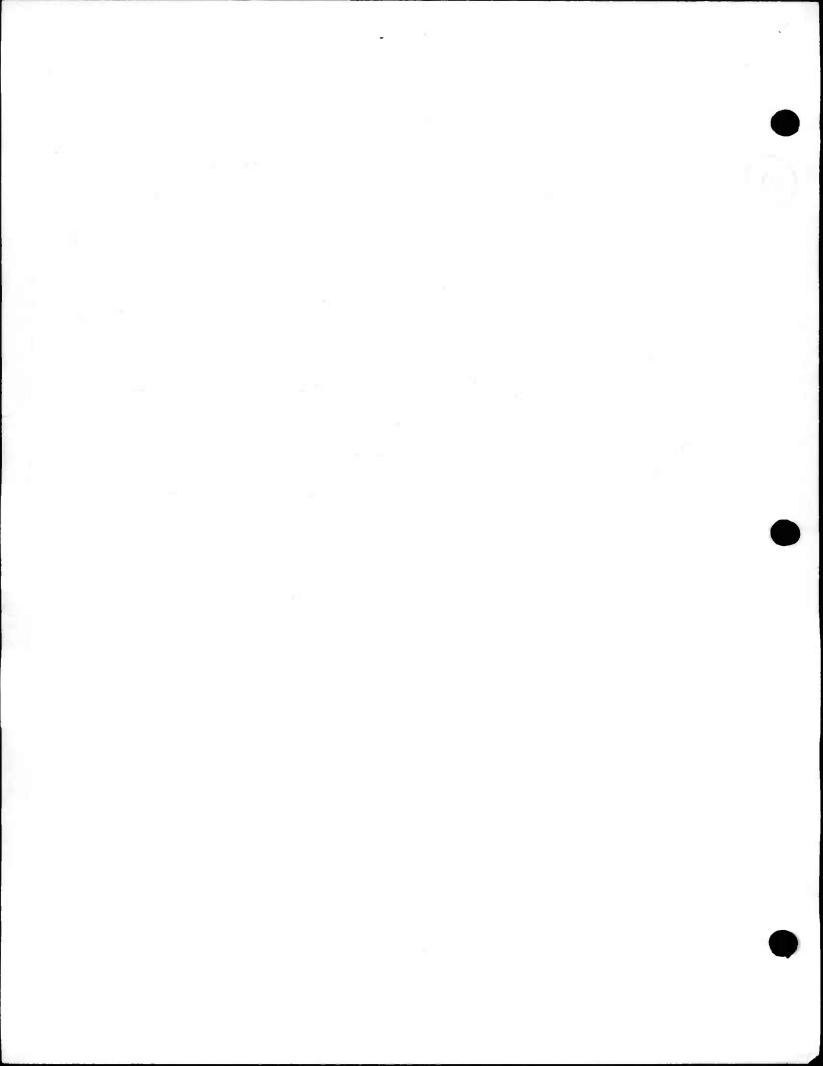
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should limit the State begs of Health and Mental Physician burial cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MA | | | OF HEALTH | | NTAL HYGIEN | | |
|---------------|---|-------------------------|--|----------------|----------------------|---------------|------------------------|--------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | 1.0 | | | 2. | DATE OF DEATH | YEA | 3. TIME OF DEATN |
| | TERE: | 50 A. | MOZIN | 40 | | | 12 6 | 9 | 08,30 m |
| | 4. SOCIAL SECURITY NUMBER 2 (5-84-6332 | | AGE (In yrs. last birthday) Z YRS. | IF UNDER | DAYS HOURS | R 24 HRS. 7. | DATE OF BIRTH | C | PATNPLACE (State or Foreign bundan) |
| | 9e. FACILITY NAME (If not institution, give s | | 28 YHS. | ah CITY | TOWN OR LOCAT | ION OF DEATH | APRILII | 9c. COUNTY C | |
| æ | ST. JOSEPH | HOSPITI | DL | | DWSE | | • | | TIMORE |
| 5 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | | | | | | | T |
| DIRECTOR | | LLTIMO | 72 F | T (9) | O S O N | > | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | | 101. ZIP COD | Œ | | 10g. CITIZEN | OF WHAT COUNTRY? |
| FUNERAL | 15 LERNE | R Cou | RT | | 121 | 236 | , | u. | 5. A. |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT E | | | MAS DECENDENT | | ORIGIN? (Specify Year | or No 14. F | RACE — American Indian, Black, White, atc. |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR | | | YES 2 NO | | | | Specify: |
| | 15. DECEDENT'S EDU | | 16a. DECEDENT | | | | 16b. KIND OF BUS | SINESS/INDUSTF | NATITE |
| <u> </u> | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 +) | Ille. Do NOT | use retired.) | furing most of worki | _ | | | |
| COMPLETED | 12YRS. | | LUSIS | 2 WTB | SERV | | BALT | | 2. Co. |
| | 17. FATHER'S NAME (First, Middle, Last) | ~ n. | . 0 | | 16. MOT | HER'S NAME | (First, Middle, Maiden | Surname) | |
| 띪 | 19a. INFORMANT'S NAME (Type/Print) | LRun, | | G ADDRESS | (Street and Number | A TR | te Number, City or Tow | State Zin Code | |
| 임 | · · · · · · · · · · · · · · · · · · · | ioros | \$2 | 2006 | A - 4 | BOK | C Nambal, Only or low | 1, State, 210 COOK | " |
| | 20a, METHOD OF DISPOSITION | | 20b. PLACE OF DISPO | SITION (Na | me of cemetery, cre- | matory or | 20c. LO | CATION — City of | or Town, State |
| | Burial 2 Cremation 3 Rem | oval from Stata | SI- JOSS | 2169 | HURCH | | FUL | LERTO | a.Mo. |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | 22. | NAME AND ADDRE | HOP) | TOFME | MORIS | S |
| | 1 1 50 | Bursh | | 8 | SOO HA | e Fore | RUAO - | Parky | وري |
| | 23. PART I. Enter the diseases, or shock, or heart failura. | | | | | | | | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final | | 2DIAC | Th | MONN | ADE | | | Onaat and Daath |
| | disease or condition resulting in death) | 8 | | | 1-14 01 | | | | |
| _ | | | RAS A CONSEQUENCE | | 0.00 | AL < | SEONIS | EEE | (5/0/0) |
| o No | Sequentially list conditions, | DUE TO (O | R AS A CONSEQUENCE | 12 L C | JAPIC D. | | DE ILUGO | LTTY | 13.01.0 |
| CAT | If any, leading to immediate cause. Enter UNDERLYING | · DIL | ATED | M | 10CA | RDI | OPATI | +7 | |
| Ē | CAUSE (Disease or Injury that initiated events | OUE TO (O | R AS A CONSEQUENCE | DF): | | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | |
| | PART II. Other significant condition | na contributing to de | eath but not resulting | in the un | derlying cause | given in Par | | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| JICAL | BILATERA | LPLEH | RALS | ERO | USE | FFUS | (8) PERFO | V. V. | COMPLETION OF CAUSE OF DEATN? |
| MED | MEDIASTINI ADRIAMY | al LYMP | HOMATR | EATE | DUITI | H | _ | | 1 [] YES 2 [] NO |
| ä | | CIN | | | | | | | |
| CE | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | _ | OTHER | 26. PLACE OF | DEATH (Check | only one) | | |
| PHYSICIAN: | 1 TYES 2 NO | 1 N Inpetient 2 E | ER/Outpetient 3 DOA | _ | sing Home 5 - F | | Other (Specify) | N HIDY OCCUPE | 70 |
| 占 | 1 Natural 5 Pending | (Month, Day, | | URY M | WORK? | 2752 | ea, DEŞCHIBE NOW | NJURY OCCURE | :0 |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF | INJURY — At home, farm | , street, fact | | | 61. LOCATION (Street | and Number or R | ural Route Number, |
| ם | 4 Nomicide determined | building, et | c. (Specify) | | | | City or Town, State | | The second secon |
| COMPLETED | 29a. CERTIFIER (Check only 1 CERTIFYING PHYS | ICIAN: To the best of m | y knowledge, death occu | rred at the t | lme, date and plac | e, and dua to | the cause(a) and ma | nner as atated. | |
| OM | 1 | | | | | | | | use(a) and manner as stated. |
| | 290. SIGNATURE AND TITLE OF CERTIFIE | R Z | | | 29c. LK | CENSE NUMBE | | | GNED (Month, Day, Year) |
| O BE | (d) | , W | 14. | | D | 131 | 40 | 12 | -6-90 |
| 5 | 30. NAME AND ADDRESS OF PERSON W | | | | " 5 | | | _ | |
| | | | ELA-GOI | NF2 | 114.0 | - | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | | | | | | | |
| | DEC 1 3 1990 | fulio Davi | A STATE OF THE PARTY OF THE PAR | | | | | | |

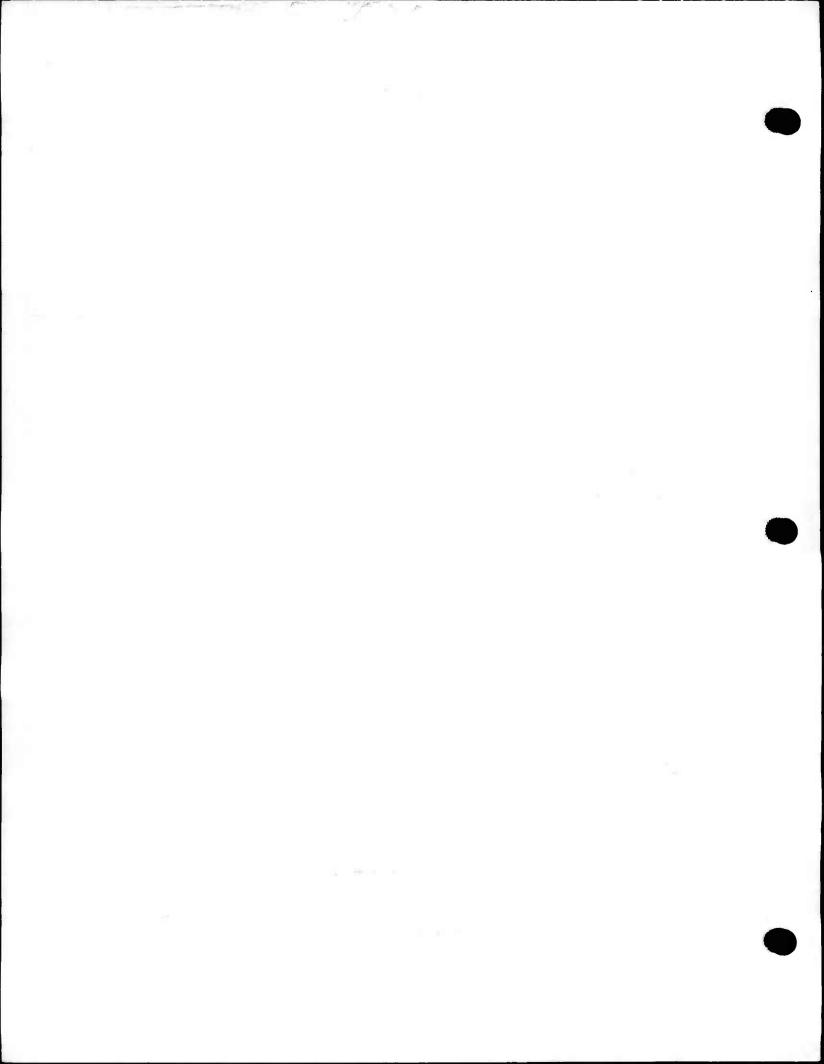
DHMH-16 Rev 1/89



permit. Pages 1, 2, 3 should (V)

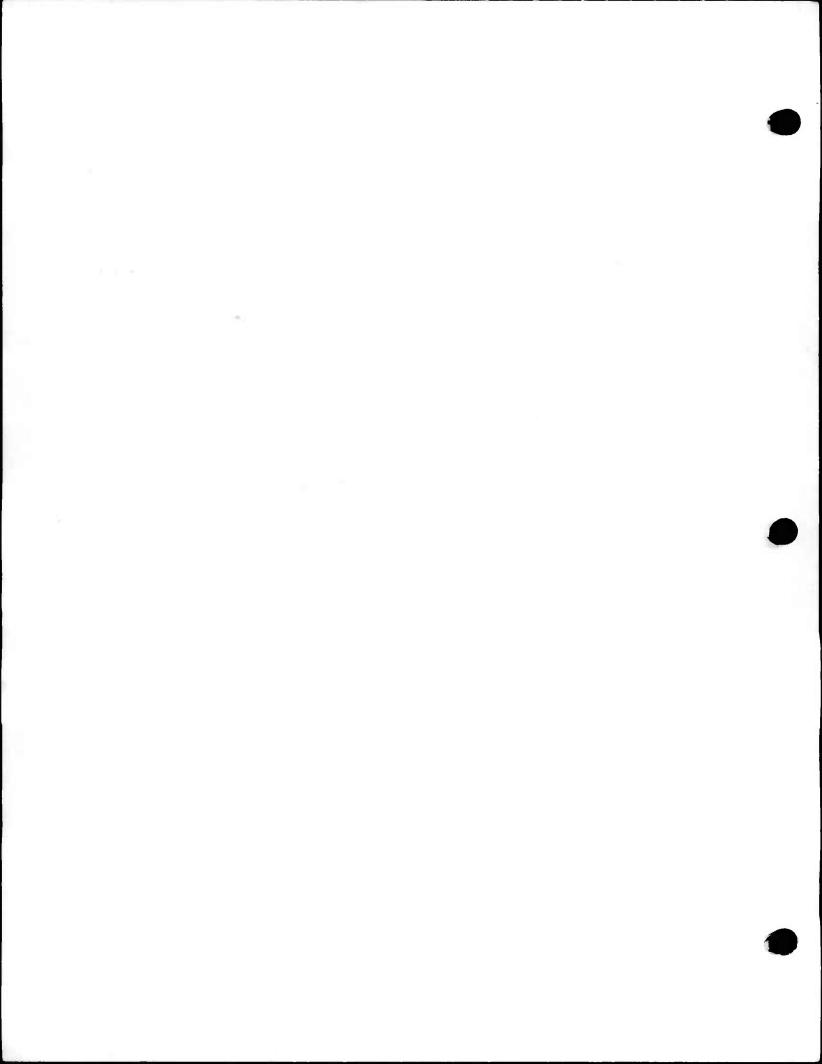
| FOR STATE REGISTRAR | STATE OF M | ARYLAND / DEPAR CERTIF | TMENT OF H | MENTAL | HYGIENE REG. NO. |
|--|------------|---------------------------|-----------------------|--------------------------|---------------------|
| B. DECEOENT'S NAME (First, Middle, Last) Violet | Annie | Nicholson | | 2. DATE O MONTH 12 | F DEATH DAY |
| COCIAL CECURITY NUMBER | 5 05V | 0 10F (butter) | and the second second | | |

| | 1 - STATE REGISTRAR | SIAIE UF M | | | ICATE | | | | | EG. NO. | E | | |
|---------------------|---|---|-----------------------|-------------------------|------------------------------|--------------|--|------------|----------------------------|-----------------------------|-------------|---------------|---|
| | 1. DECEOENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF I | DEATH | | | 3. TIME OF DEATH |
| | Violet | Annie | Nicho | lson | | | | | | | | L990 | 3:30PM M |
| | 4. SOCIAL SECURITY NUMBER | | 6. AGE (In yrs. las | st birthday) | IF UNDER | | IF UNDER | | 7. DATE OF E (Month, De | BIRTH | | 8. BIRTHE | PLACE (State or Foreign |
| | 218 05 8551 | 1 □ M 2 √√F | 93 | YRS. | MONTHS | DAYS | HOURS | MIN. | March | 10, | 1897 | Dela Dela | aware |
| | Se FACE ITY NAME (If not institution give s | | | 9b. CITY, | TOWN C | R LOCATIO | | | | | NTY OF DE | EATH | |
| RO | Berlin Nursing Ho | me Rt. II | Gitv ^O BI | lvd. | Ber1 | lin. | Mar | v1an | d | | Wor | ceste | er |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| 표 | | 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | 10d. INSIDE CITY LIMITS? | | | |
| 0 | | | | | lin | 17.00 | | | | | | | 1X YES 2 NO |
| RA | 10e. STREET AND NUMBER | | | | | | ZIP CODE | | | | | | HAT COUNTRY? |
| FUNERAL DIRECTOR | Rt. 113 & Old Oce | EVER IN U.S. AF | | | | | U.S.A. NIC ORIGIN? (Specify Yee or No. 14. RACE - | | | | | | |
| 品 | 1 Never Merried 2 Married | FORCES? 1 | YES 2 7 | NO NO | - In | yes, spe | city Cube | n, Mexice | n, Puerto Ricar | | or No— | Black, | — American Indien, White, etc. |
| BY | 3 X Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 1 | ☐ YES | 2 📉 NO | Specify | <i>r</i> : | | | Specif | w White |
| COMPLETED | 15. DECEDENT'S EDU | CATION | | | USUAL OC | | | | 16b. KIN | ID OF BUS | SINESS/IN | DUSTRY | |
| H | (Specify only highest grede Elementary/Secondary (0-12) | College (1-4 or 5 + | Hife | ive kind of Do NOT u | work done di se retired.) | uring mo | st of workin | g | | | | | |
| ם | 3 | | | ısewi | fe | | | | | | | | |
| ő | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NA | ME (First, Middi | ie, Maiden | Sumame) | | |
| BE C | Leonard | 0 | Guthrie | | | | Flo | renc | e | | | Ti | lghman |
| | 19e. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | AOORESS | (Street e | nd Number | or Rural F | Poute Number, (| City or Tow | n, State, Z | p Code) | |
| 10 | Rose Venable | | 1 | Kt. 1 | , Box | 31 | . / ВВ | | 0cear | n Cit | y, N | D : | 21842 |
| | 20e. METHOD OF DISPOSITION | ovel trom State | 20b. PLACE other p | | SITION (Nar | ne of cen | netery, crem | natory or | | 20c. LO | CATION - | City or Tov | wn, State |
| | to Buriel 2 ☐ Cremetion 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | - Communication | What | | Cemet | tery | , | | | Sno | tH w | 111, 1 | Maryland |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | 22. N | NAME AN | O ADDRES | S OF FA | CILITYBUE'D | age. | Fune | ral 1 | Home |
| | 1. July | Buchon | | | | | | | | Lin, | | 218 | |
| | 23. PART I. Enter the diseases, or | complications that | caused the de | eath. Do | not enter | the mo | de of dvi | na. suci | | | | | Approximate |
| | shock, or haert fallure. | List only one/ceu | se on each line | 0. | | | | | | | | | interval Between Onset and Death |
| | iMMEDIATE CAUSE (Finel disease or condition | 0 | NEI | 2007 | カノム | | | | | | | | Oneet and Death |
| | resulting in deeth) | | | | | | | | | | | | |
| _ | | . / | OR AS A CONSE | Res | 1 | | | | | | | | Ì |
| 5 | Sequentially list conditions, if sny, leading to immediate | DUE TO | OR AS A CONSE | OUENCE C | F): | | | | | | | | |
| 8 | ceuse. Enter UNDERLYING CAUSE (Disease or injury | G | 49 | R | | | | | | | | | |
| E | that initieted events | OUE TO | OR AS A CONSE | QUENCE C | F): | | | | | | | | |
| EH | reaulting in death) LAST | d | | | | | | | | | | | |
| DICAL CERTIFICATION | PART II. Other significent condition | ns contributing to | death but not | resulting | In the un- | derivino | cause o | ni nevic | Part I. 24 | a. WAS AN | AUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| S | | _ | | | | | , | , | | PERFO | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | 1 | YES 2 | 2 NO | | OF DEATH? |
| Σ | | | | | | | | | — | | | | 1 TES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | _ | | 26 PI | ACE OF D | FATH (Ch | eck only one) | | | | |
| PHYSICIAN: ME | EXAMINER? 1 YES 2 NO | HOSPITAL: | ED/Outpetlant | 2 🗆 DOA | OTHER | t: | | | | 4 1 | | | |
| ¥ | 27. MANNER OF DEATH | 28e. DATE OF | INJURY | 28b. TII | AE OF | 28c. INJ | | eldence | 8 Other (Sp 28d. OESCRI | | INJURY O | CCUREO | |
| 4 | 1 Netural 5 Pending | (Month, De | ny, Your) | ĺN | JURY | | PRK? YES 2 | NO | | | | | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not be | 28e. PLACE O | F INJURY At h | ome, farm, | street, facto | ory, offic | • | | 281. LOCATIO | ON (Street | end Numb | er or Rural R | Route Number, |
| | 4 Homicide determined | building, | etc. (Specify) | | | | | | City or To | own, State, |) | | |
| COMPLETED | 29e. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of | mu knowledge d | anth assure | and at the t | det- | | and due | to the second | | | | |
| MP | | | | | | | | | | | | |) end menner ee stated. |
| | 29b. SIQNATURE AND TITLE OF CERTIFIE | | | | | | _ | | | 7,1000,100 | | | |
| BE | | | 2 | | | | | ENSE NUI | MBER | | | | (Month, Day, Year) |
| 2 | Federico G. Art 30. NAME AND ADDRESS OF PERSON WI | · · · · · · · · · · · · · · · · · · · | | M 27 /5- | Delents / | _ | D020 | 20 | | | | Jeceill | ber 8, 1990 |
| | Federico G. Art | | B ay St | | | lin | MD | 2121 | 11 | | | | |
| | 21 DATE Ell ED (Month Cor. Vest) | 22 DECISTRA | D'O CIONATURE | | DET. | 4.111 | עוויז | 2101 | L. L. | | - | | |
| | DEC 1 3 1990 | Sile Baird | son Rand | 20. | | | | | | | | | |
| | 020 40 1000 | 41 | | | | | | | | | | | |



| | Pages 1. | |
|--|--|--|
| | 1 | |
| 3-314 | ending physicians as the bond france |) |
| BALTIMORE, MARYLAND 21203-3146 | er death. Page 6 may be retained by the hospital or att the funeral director, page 5 should be detached for use val. | examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the death certificate because that the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the manufacture of the property of the second property of the property of th | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | HEGISTHAH | | | | | CAIL | VI . | | | 1.1 | EG. NO. | | | |
|--|---|---|--|---|---|--|---|---|--|--|--|--|------------------|--|
| | 1. DECEDENT'S NAME (First, ELEANOR M | | ζ | | | | | | | 2. DATE OF S | DEATH | | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER 1 Y | EAR | IF UNDER | 24 HRS. | 7. DATE OF 8 | | | | PLACE (State or Foreign |
| | 219-16-264 | | 1 🗆 M 2 💢 🗶 | 67 | YRS. | | | HOURS | MIN, | 05/19 | /23 | | Country, | alto, MD |
| | 9e. FACILITY NAME (If not in | stitution, give stre | eet and number) | | | 9ь. СІТҮ, ТО | OWN OR | LOCATIO | ON OF DEA | тн | | | TY OF DE | |
| Ö | UNION MEMO | | DSPITAL | | | BALT | IMOI | RE, | MARY | LAND | | Balt | 0 C1 | ty |
| ត្ត | RESIDENCE OF DEC | 10b. COUNTY | | | 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | 10d. INSIDE CITY | | | | |
| DIRECTOR | MD | Bal: | to City | | Balto City | | | | LIMITS? 1XXYES 2 NO | | | | | |
| BY FUNERAL | 100. STREET AND NUMBER 4240 ELS | 100. STREET AND NUMBER 4240 Elsa Terrace | | | | 10f. ZIP CODE 21211 | | | | 10g. CITIZEN OF WHAT COUN | | | | |
| Ξ | 11. MARITAL STATUS | | 12. WAS DECEDEN | IT EVER IN U.S.AR | MED | 13. WA | S OECER | NOENT O | F HISPANIC | C ORIGIN? (S | pecify Yee | or No- | 14. RACE | - American Indian |
| L | 1 Never Merried 2 | Merried | FORCES? 1 | YES 2 | 6 | If y | es, spec | ty Cuber | , Mexican, Specify: | Puerto Ricer | ı, etc.) | | | White, etc. |
| | 3 Widowed 4 Divo | rced | W 123, GIVE V | WIT ON DATES | | '' | 163 2 | AT NO | зресну. | | | - 1 | apecin | White |
| 15. DECEDENT'S EOUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) | | | | | | | | | | | | | | |
| | Elementary/Secondary (0 | | College (1-4 or 5 | (Gi | Do NOT us | vork done dun e retired.) | ing most | of working | g | | | | | |
| 4 | a.oy.cocoy (c | , | | " | Hom | emake | r | | | 1 | | - | | |
| Elementary/Secondery (0-12) College (1-4 or 5+) HOmemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| 监 | 19e. INFORMANT'S NAME (7 | | | 190 | b. MAILING | ADDRESS (S | Street and | d Number | | oute Number, C | | n. Stete. Zip | Code) | |
| 2 | Francis | | r Pettv | | | | | | | ace B | | | | 21211 |
| | | | | 20h PLACE | OF DISPOS | ITION (Name | of como | done const | aton or | ice D | | | | |
| 20s. METHOD OF DISPOSITION ***D'Suriel 2 Cremetton 3 Removal from State 4 Donetton 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cametery, crematory or other place) Garrison Forest VA Carrison, MD | | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSES. 22. NAME AND ADDRESS OF FACILITY BURGEE—HENSS FUNERAL HOM | | | | | | | JERAI HOME | | | | | | | |
| | 3631 Falls Rd Baltimore, Maryland 21211 | | | | | | | | | | | | | |
| | 23. PART i. Enter the d | isees for co | omplications the | nt coused the de | eth. Do r | ot enter th | e mode | e of dyl | ng, such | ae cardlec | or reepi | ratory arr | eet, | Approximata |
| | ahock, or heart failure. List only one ceuse on each line. | | | | | | | | | interval Between Onset end Deeth | | | | |
| | IMMEDIATE CAUSE (Fir disease or condition | nel | | Acute 1 | 47 | and. | 10 | 1121 | fre | hont | lail | ure (| a conte | |
| | resulting in death) | • | OUF TO | (OR AS A CONSE | DUENCE O | FI- | | 1 | • | /// | 0 | | | 212 40 |
| _ | | _ | (A) |) | JOENOL O | ,, | | | | | | | | į _ |
| 9 | Sequentially list condit if any, leading to imme | | DUE TO | (OR AS A CONSE | DUENCE O | F): | | | | | | | | |
| 5 | cause. Enter UNDERLY | ING | | _ | | | | | | | | | | - |
| | that initiated events | ", | DUE TO | (OR AS A CONSE | DUENCE O | F): | | | | | | | | |
| | reaulting in death) LAST | | | | | | | | | | | | | |
| ERTIFI | reaulting in death) LAS | T d | | d | | | | | | | | | | |
| 8 | | d | contributing to | death but not a | ensiting. | in the unde | rlving | COLLOG C | siven in E | Part I 24 | MACAN | AUTOREY | 245 | WERE AUTOROV CAIDIAGO |
| 빙 | PART II. Other eignification | d | contributing to | death but not i | eauiting | in the unde | erlying | ceuae g | jiven in P | Part I. 24s | . WAS AN | AUTOPSY MED? | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| 빙 | | d | contributing to | death but not i | reauiting | in the unde | erlying | ceuae g | jiven in P | | | MED? | | |
| MEDICAL CE | | d | contributing to | death but not i | reauiting | in the unde | erlying | ceuse g | given in P | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL CE | PART II. Other eignifica | ent conditions | contributing to | death but not i | reaulting | in the unde | erlying | cause g | given in P | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL CE | | ent conditions | | death but not r | reaulting | | | | | | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL CE | PART II. Other eignifica | ent conditions | HOSPITAL: | death but not r | | OTHER: | 26. PLA | CE OF O | EATH (Chec | _ 1(| PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL CE | 25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | ent conditions | HOSPITAL: 1 Inpetent 2 [26e, DATE Of | □ ER/Outpatient 3 | □ 00A | OTHER: 4 Nursin | 26. PLA | CE OF O | EATH (Chec | 1 { | PERFOR | NO NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL CE | PART II. Other eignification of Death 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 | ent conditions | HOSPITAL: | □ ER/Outpatient 3 | □ 00A | OTHER: 4 Nursin | 26. PLA | S Re | EATH (Chec | ck only one) | PERFOR | NO NO | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Accident | ont conditions O MEDICAL | HOSPITAL: 1 Inpetient 2 28e. DATE 0 28e. PLACE 0 | □ ER/Outpetlent 3 FINJURY ay, Year) OF INJURY — At ho | OOA 28b. TIM | OTHER: 4 Nursin E OF 20 URY | 26. PLA og Home 8c. INJUI WOR 1 YE | S Re | EATH (Checked and Checked and | 1 { Ck only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) | PERFOR | NO NO NJURY OC | CURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Netural 5 Accident | ent conditions O MEDICAL Pending investigation | HOSPITAL: 1 Inpetient 2 28e. DATE 0 28e. PLACE 0 | ER/Outpetient 3 F INJURY ay, '6ar') | 28b. TiM | OTHER: 4 Nursin E OF 20 URY | 26. PLA og Home 8c. INJUI WOR 1 YE | S Re | EATH (Checked and Checked and | 1 { Ck only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) Ch only one) | PERFOR | NO NO NJURY OC | CURED | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide | Pending Investigation Could not be determined | HOSPITAL: 1 Inpatient 2 28e. DATE Of (Month., (Month.) 28e. PLACE (building) | ER/Outpatient 3 FINJURY ay, 'bar') OF INJURY — At ho, etc. (Specify) | 28b. TIM | OTHER: 4 Nursin E OF 20 URY M street, fectory | 26. PLA og Home 8c. INJUI WOR 1 YE | 5 Re RRY AT AT AT AT AT AT AT AT AT AT AT AT AT | EATH (Check the state of the st | 1 [Other (Sp. 286. DESCRII City or To | PERFOR | NO NO NJURY OCI | CURED or Rural R | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Accident 3 Suicide 6 A Homicide 29e. CERTIFIER (Check only) | Pending Investigation Could not be determined | HOSPITAL: 1 Inpatient 2 26e. DATE Of (Month., Inc.) 28e. PLACE (building) | ER/Outpatient 3 FINJURY ay, 'bar') OF INJURY — At ho, etc. (Specify) If my knowledge, de | 28b. TIM | OTHER: 4 Norsin E OF 2/ E OF 2/ M street, factory | 26. PLA og Home 8c. INJUI WOR 1 YE y, office | SCE OF OIL 5 Re Re RY AT ACCES 2 Re Res Re Re Re Re Re Re Re Re Re Re Re Re Re | EATH (Checkedence 8 | 1 [Ck only one) Charles Charl | PERFOR YES 2 DOCATIVE DIN (Street of wwn, State) DIN (or other | NO NO NO NO NO NO NO NO NO NO NO NO NO N | OURED or Rural R | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Accident 3 Suicide 6 A Homicide 29e. CERTIFIER (Check only) | Pending Investigation Could not be determined TIFYING PHYSIC | HOSPITAL: 1 Inpatient 2 26e. DATE Of (Month., Inc.) 28e. PLACE (building) | ER/Outpatient 3 FINJURY ay, 'bar') OF INJURY — At ho, etc. (Specify) If my knowledge, de | 28b. TIM | OTHER: 4 Norsin E OF 2/ E OF 2/ M street, factory | 26. PLA og Home 8c. INJUI WOR 1 YE y, office e, date e | SCE OF O | EATH (Checkedence 8 | 1 [Other (Sp. 28d. OE\$CRII City or To | PERFOR YES 2 DOCATIVE DIN (Street of wwn, State) DIN (or other | NO NO NO NO NO NO NO NO NO NO NO NO NO N | or Rural R | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only one) 2 MED | Pending Investigation Could not be determined | HOSPITAL: 1 Inpatient 2 28e. DATE Of (Month, I) 28e. PLACE of building BIAN: To the best of a: On the basic of a | DF INJURY — At ho, etc. (Specify) If my knowledge, department on end/or | 29b. TIM N N Hne, farm, | OTHER: 4 Norsin E OF 2/ E URY M street, fector ed at the timen, in my opti | 26. PLA og Home 8c. INJUI WOR 1 YE y, office e, date e | 5 Re RY AT / ES 2 Common place, ath occur | EATH (Check stellars) NO NO not set at the times NUMBERSE NUMBERS NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE | 28f. LOCATIO City or 76 o the cause(a lime, date and BER | PERFOR | NJURY Oci | or Rural R | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO oute Number, |
| COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only only only) 2 MED 29b. SIGNATURE AND TITLE | Pending Investigation Could not be determined TIFYING PHYSIC PERSON WHO | HOSPITAL: 1 Inpatient 2 O 28e. DATE (Month., (Month.) 28e. PLACE (building) 28e. PLACE (c) 28e. | DF INJURY — At ho, etc. (Specify) If my knowledge, department on end/or | 29b. TIM N N Hne, farm, | OTHER: 4 Norsin E OF 2/ E URY M street, fector ed at the timen, in my opti | 26. PLA og Home 8c. INJUI WOR 1 YE y, office e, date e | 5 Re RY AT / ES 2 Common place, ath occur | EATH (Check stellars) NO NO not set at the times NUMBERSE NUMBERS NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE | 1 [Other (Sp. 28d. OE\$CRII City or To | PERFOR | NJURY Oci | or Rural R | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Oute Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED T EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CETTIFIER (Check only one) 2 MED 29b. SIGNATURE ANO TITLE 30. NAME ANO ADDRESS O | Pending Investigation Could not be determined TIFYING PHYSIC PERSON WHO | HOSPITAL: 1 Vinpetlent 2 28e. DATE Of (Month, L.) 28e. PLACE C building CHAN: To the best of the complete of t | DER/Outpatient 3 FINJURY DE INJURY — At ho, etc. (Specify) If my knowledge, de examination end/or | 28b. TIM IN, IN, In, In, In, In, In, In, In, In, In, In | OTHER: 4 Norsin E OF 2/ E URY M street, fector ed at the timen, in my opti | 26. PLA og Home 8c. INJUI WOR 1 YE y, office e, date e | 5 Re RY AT / ES 2 Common place, ath occur | EATH (Check stellars) NO NO not set at the times NUMBERSE NUMBERS NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE NUMBERSE | 28f. LOCATIO City or 76 o the cause(a lime, date and BER | PERFOR | NJURY Oci | or Rural R | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Oute Number, |



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| OF VITAL RECOR | PHYSICIAN; The law requires that | this certificate has been signed t | nows are death with the State Dept. of Health a | d, or item 23 shows an |
|----------------|----------------------------------|------------------------------------|---|---|
| O KOISIMIA | TO THE HOSPITAL OR PETERDING PHY | TO THE FUNERAL DIRECTION THIS | be filed within 72 hours are death with | IMPORTANT: It item 28 is marked, or item 23 shows any |

| The law requires that the death certificate be executed within Zamburs after death. Page 6 may be retained by the hospital or attending physician. | e has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | in about with the State Dept. of Health and Mental Hygiene prior to burtal, cremation, or removal. | is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
| uires tha | signed | Health a | WE any |
| aw req | s been | ept. of | 23 she |
| : The l | ate ha | tate De | tem 2 |
| SICIAN | certific | the S | , or i |
| PHY | this certi | Hatt with | marked |
| 曹 | | 10 Te | 69 |

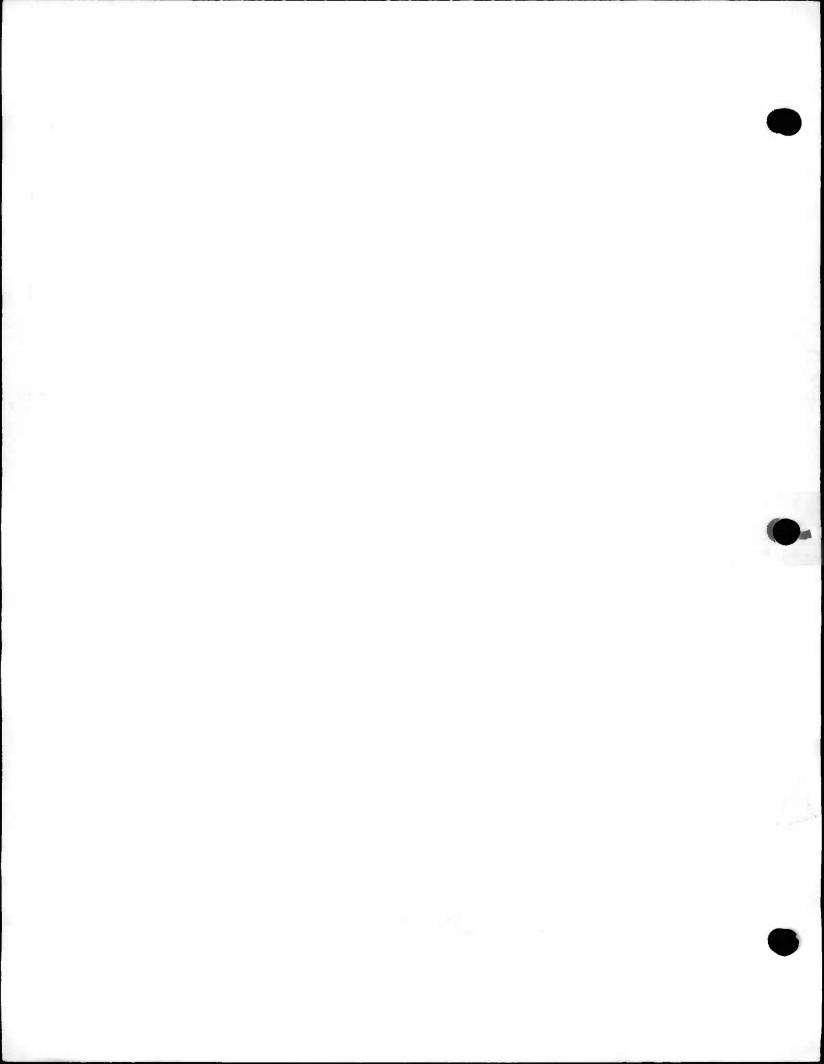
TO BE COMPLETED BY FUNERAL DIRECTOR

| | | 90 34190 |
|--|---|--|
| 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND M CERTIFICATE OF DEATH | | |
| | REG. NO. | 3. TIME OF DEATH |
| Managara D Our | MONTH DAY | 37 2215 P |
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. leat birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign |
| 217-66-67% 1 - M 2 X F 35 YRS. MONTHS DAYS HOURS MIN. | (Month, Day, Year) 55 | Country) N.C. |
| ST AGNES HOSPITAL BALTIMOR | TH Sc. C | COUNTY OF OEATH |
| 100. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | 10d, INSIDE CITY |
| MD BACTMOKE | | LIMITS? |
| 100. STREET AND NUMBER 101. ZIP CODE 1.1. ZIP CODE | 10g. | CITIZEN OF WHAT COUNTRY? |
| 2829 W. MULBERRY STREET 2/223 | | 4.5.4 |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ABMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. Wildowed 4 Olvorced 14. WAS DECEDENT OF HISPANK If yes, specify Cuban, Mexican, 1 YES 2 NO Specify: | | - 14. RACE — American Indian, Black, White, etc. Specify: |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working | 16b. KIND OF BUSINESS | 3/INDUSTRY |
| Elementary/Secondary (0-12) College (1-4 or 5+) | | |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAM To be a second of the secon | E (First, Middle, Maiden Surnen | ne) |
| 19a_INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Ric | TOP CITY IV | 7h Codel |
| Calupnia G. Smith 6413 85th Place | New Carre | 114 11/20184 |
| 20a, METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Removal from State Donation 5 Other (Specify) | Park Rune | N-City or Town, State |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE A 22. NAME AND ADDRESS OF FACE A 22. NAME AND ADDRESS OF FACE A 23. NAME AND ADDRESS OF FACE A 24. NAME AND ADDRESS OF FACE A 25. NAME AND ADDRESS OF FACE A 26. NAME AND ADDRESS OF FACE A 36. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 46. NAME AND ADDRESS OF FACE A 56. NAME AND ADDRESS OF FACE A 56. NAME AND ADDRESS OF FACE A 56. NAME AND ADDRESS OF FACE A 56. NAME AND ADDR | H. West wabash | Ave |
| 23 PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. | aa cardiac or reapiretory | y arreat, Approximeta Interval Between |
| IMMEDIATE CAUSE (Fine) disease or condition resulting in death) e. A COS | | Onset and Daeth |
| DUE TO (OR AS A CONSEQUENCE OF): | | |
| 4+De Myruttes | | |
| Sequentially list conditions, If any, leading to immediate | | |
| cause. Enter UNDERLYING CAUSE (Disease or Injury | | |
| that initiated events resulting in death) LAST | | |
| DAPT II Other clearlifeant and little and anti-little As death but not assisted by the | | |
| PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in F | Part I. 24s. WAS AN AUTO PERFORMEO? 1 YES 2 1 | AWAILABLE PRIOR TO |
| | _ | 1 TYES 2 NO |
| | | |

| | | | | | _ | |
|----------------------------------|---|-----------|--------------|-------------------------|--------------------------------|----|
| 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PLACE OF OEATH (C | theck only one) | |
| EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient | | OTHE 4 Nu | | 8 Other (Specify) | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b, TIMI | E OF URY | 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCUP | ED |

| 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 | □ DOA 4 □ Nu | R: raing Home 5 - Residence | 8 Other (Specify) | | |
|---|---|-----------------------------|---------------------------------|---|--|--|
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW INJURY OCCURED | | |
| 3 Suicide 8 Could not be determined | 28e. PLACE OF INJURY — A! ho building, etc. (Specify) | me, farm, street, fac | ctory, office | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | |

| MEDICAL EXAMINEN: On the beste of examination end/or investigation, in my opinion, d | leath occured at the time, date end place, en | id due to the ceuse(e) end manner ee stated. |
|--|---|--|
| b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |



| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | D / DEPAR | | | | ENTAL HYGIENI REG. NO. | E | | |
|--------------------|--|--|--------------------------------|---------------------|---------------------|-----------------------------------|---|---------------------------------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) REYNDLDS | CHARLES CHARLES | | Reyno | lds) | | 2. DATE OF DEATH | Y | 3. TIME OF DEATH | |
| | 000 05 5505 | | 71 vrs. | IF UNDER 1 Y | EAR IF UNDE | | 7. DATE OF BIRTH 0/-06-1919 | 8. BIRT Coun Mar | HPLACE (State or Foreign Viry) | |
| E | 9a. FACILITY NAME (# not institution, give stree University of Mary | | 1 | | | TION OF DEATH 9c. COUNTY OF DEATH | | | | |
| 010 | RESIDENCE OF DECEDENT | Tand nospita | | | | imore City | | | | |
| FUNERAL DIRECTOR | Maryland 106. COUNTY | | | timor | e City | | | 10d. INSIDE CITY YULIMITS? 1 YES 2 NO | | |
| JERAL | 314 South Wolfe St | reet | | 101. ZIP CODE 21231 | | | | States | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Narried 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN U. FORCES? 1 X YES : IF YES, GIVE WAR OR DATE WW I I | 2 NO | | | | | or No 14. RAC Blac Spe | CE — American Indian, ck, White, arc, ccity: White | |
| COMPLETED | 15. DECEDENT'S EDUCAT (Specify only highest grade core (Specify only highest grade core (Particular (Specific only 10-12) 8 Yrs | Give kind of the Do NOT us Truck | work done duri se retired.) | ng most of worl | king | HIELE VC VETURE | smess/moustry ransportation | | | |
| BE COM | | | | | | | E (First, Middle, Maiden Clarkson | Sumame) | | |
| 10 B | 19a. INFORMANT'S NAME (Type/Print) Josephine Reynold | ls | | | | | et Balto. | | 231 | |
| | 20b. PLACE OF DISPOSITION 1 N Burlet 2 Cremetton 3 Removal from State 4 Donatton 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or other place) Garrison Forest Veteran Cemetery Garrison, Maryland | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | owell-Se | lines | 6 Lil | | Zeiler | Inc. Fu | | | |
| | 23. PART I. Epter the diseases, or con | nplications thet ceused the | he deeth. Do i | | | | | | Approximate | |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | ACUTE N | | OGE | Nous | s LE | EKEMI | A | interval Between Onset and Death | |
| N | DUE TO (OR AS A CONSEQUENCE OF): DIFFUSE HYSTOCYTIC LYNTHOUA 1983 Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 1983 | |
| ICATIO | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | PAL SUBDURAL HEMAD | | | EMATON | JA. | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | FUNGA | L I | EDIFFICO | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algorificant conditions of the BiLieu Failure | | | | | | 1 YES 2 | MED? | Ab. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | OTHER: | 26. PLACE OF | | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIS | IE OF 20 | Ic. INJURY AT WORK? | | 8 Other (Specify) 28d. DE\$CRIBE HOW I | NJURY OCCURED | | |
| ED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26s. PLACE OF INJURY — building, etc. (Specify) | At home, farm, | | | | 281. LOCATION (Street a City or Town, State) | | l Route Number, | |
| COMPLETED | 000) | AN: To the best of my knowled On the basis of examination a | | | | | | | e(a) and menner as stated | |
| BE | AND STONATURE AND TITLE OF CERTIFIER | uu.o | | | | CENSE NUM | | | ED (Month, Day, Year) | |
| 5 | 30. NAME AND ACCORDS OF PERSON WHO PERSON WHO | COMPLETED CAUSE OF DEATH | H (ITEM 27) (Type | Print) | | | | | 7-3 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNAT | URE | | | | 31- | | | |

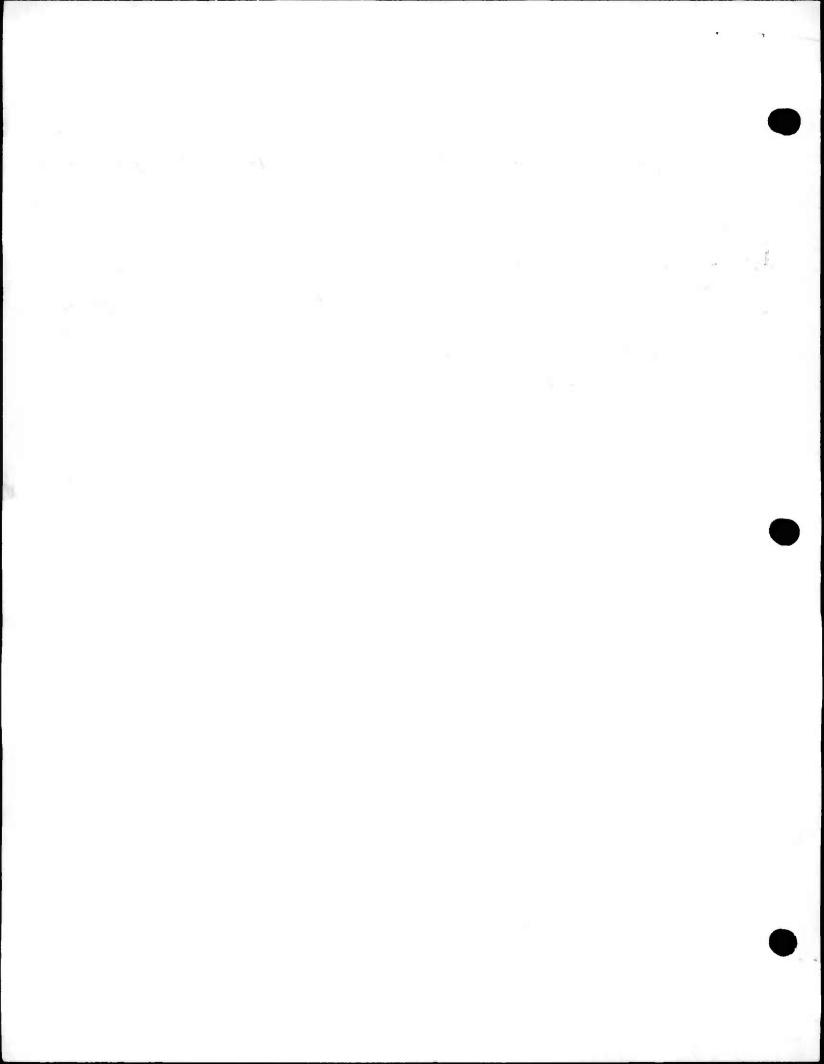
 FOR STATE REGISTRAR

| BALLIMOHE, MARYLAND 21203-3146 | e retained by the hospital or attending physician. | e 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | notified at once. |
|--|--|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALLIMORE, M. | THE STATE OF THE NAME OF THE NAME OF THE NAME OF THE OFFICE OFFICE OF THE OFFICE OFFICE OFFICE OFFICE OFFICE OFFIC | All principles where this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| - | TO THE HOSP | TO THE FUNER | IMPORTANT: |

| | 1. DECEDENT'S NAME (First, Middle, Last) | A h//- | | | 2. DATE OF DEATH | YEAR | 3. TIME OF DEATH | | | |
|---------------|---|---|---|-------------------------------------|--|----------------------|---------------------------|--|--|--|
| | 4. SOCIAL SECURITY NUMBER 5. S. | AIVE | iliza z 11 minuti il | | 12 9 | 90 | 4:50 A " | | | |
| | 1/20 -11 11000 | EX 6. AGE (In yrs. las | " | EAR IF UNDER 24 HRS. AYS NOURS MIN. | 7. DATE OF BIRTH | G. BIRT | | | | |
| | 9e. FACILITY NAME (If not institution, give street as | | | OWN OR LOCATION OF OR | 1-25-/ | 9c. COUNTY OF I | DEATH | | | |
| O.B. | DEATON HOSPITAL MEDICAL CATE BALTIMORE, Mil | | | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | 10c. CITY, TOWN OR | 10d. INSIDE CITY | | | | | | |
| E | ma. | | 139 | 1 to. | | LIMITS? | | | | |
| \¥ | 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | | |
| FUNERAL | 2710 West Mosher Street 2/216 4.5A | | | | | | | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | WAS DECEDENT EVER IN U.S. AB FORCES? 1 1 YES 2 1 F YES, GIVE WAR OR DATES | | es, epecify Cuben, Mexico | n, Puerto Ricen, etc.) | | | | | |
| BY | 3 Wildowed 4 Divorced | F YES, GIVE WAR OR DATES? | 11 | YES 2 NO Specifi | у: | Spec | olly: 13/ACK | | | |
| E | 15. DECEOENT'S EDUCATION (Specify only highest grade complete) | (G. | CEDENT'S USUAL OCC five kind of work done duri Do NOT use retired.) | | 18b. KINO OF BUS | aid | Cont | | | |
| PLE | Elementery/Secondery (0-12) Col | Hege (1-4 or 8+) | use Keen | oing | Balto | , City | Horre | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 170 | | | ME (First, Middle, Malden | Surname) | 7 7 | | | |
| BE | Toby BACKEM Boline Brack | | | | | | | | | |
| 5 | 190. IMPORMANT'S NAME (Type/Prigit) | 190 | 24/0 H | sher St | Route Number City or Town | | 2/2/6 | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Removal for | rom State 20b. PLACE other pla | OF DISPOSITION (Name | of cemetery, cremetery or | 20c. LO | CATION — City or T | own, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| | ► MILA R | Variation 1 | 4 | arch F | 4.Wes7 | | 0 11. | | | |
| \vdash | 23. PARY I. Enter the diseases, or comp | lications that caused the de | eth Do not enter th | a made of dular and | 4300 U | 1aspent | Approximata | | | |
| | ahock, or haart fallure. List o | only one cause on each line | l. | a moda or dynig, suc | in aa cardiac or respi | iotory arreat, | Intarval Between | | | |
| | disease or condition a. 9 day | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| N O | Sequentially list conditions, DUE TO (OR AS A CONSCOUENCE OF): | | | | | | | | | |
| CAT | If any, laading to immediata cause. Entar UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated evants resulting in death) LAST | | | | | | | | | |
| EH | d. | | | | | | | | | |
| CAL | PART II. Other algnificant conditions con | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | | | | |
| EDIC | Tupus Tythe myllosies 1 yes 2 NO COMPL | | | | | | | | | |
| Σ | Dealita Wells | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) | | | | | | | | | |
| Sic | EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify) | | | | | | | | | |
| 됩 | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. OATE OF INJURY (Month, Day, Year) | INJURY | Ic. INJURY AT WORK? | 28d. DEŞCRIBE HOW I | NJURY OCCURED | | | | |
| B | 2 Accident Investigation | 28e. PLACE OF INJURY — At he | | 1 YES 2 NO | and a Contribution | Luminut . Acc | | | | |
| 윤 | 3 Suicide 8 Could not be determined | building, etc. (Specify) | ome, iairm, street, iactor | , отнов | 28f. LOCATION (Street of City or Town, State) | ind Number or Hurili | Houte Number, | | | |
| LE] | 290. CERTIFIER 1 CERTIFYING PHYSICIAN: | : To the best of my knowledge, de | eath occurred at the tim | date and place, and dur | to the couse(e) and mer | ner se stated. | | | | |
| COMPLETED | Land 1 | the basic of examination end/or | | | | | (e) end menner ee stated. | | | |
| ш | 296. SIGNATURE AND TITLE OF CERTIFIER | 10/ | 1- h | 29c. LICENSE NU | MBER | 29d. DATE SIGNE | O (Month, Day, Year) | | | |
| то в | porando 1 | 1/1000 | MI | 1001 | 860 | 12 | -9-70 | | | |
| | TO NAME AND ADDRESS OF DEBROOK WHO CO | MPLETED CAUSE OF DEATH (ITE | M 27) (Typi, Print) | 2 | | | | | | |
| 1 | 30. NAME AND ADDRESS OF PERSON WHO COL | att & M | Peleil (| enter | | | | | | |
| | Destin for | util & M | Robert Ca | enter, | | | | | | |
| | Destin for | 32 REGISTRAR'S SIGNATURE Julia Davidson-Ro | Robert Ca | enter, | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

34192



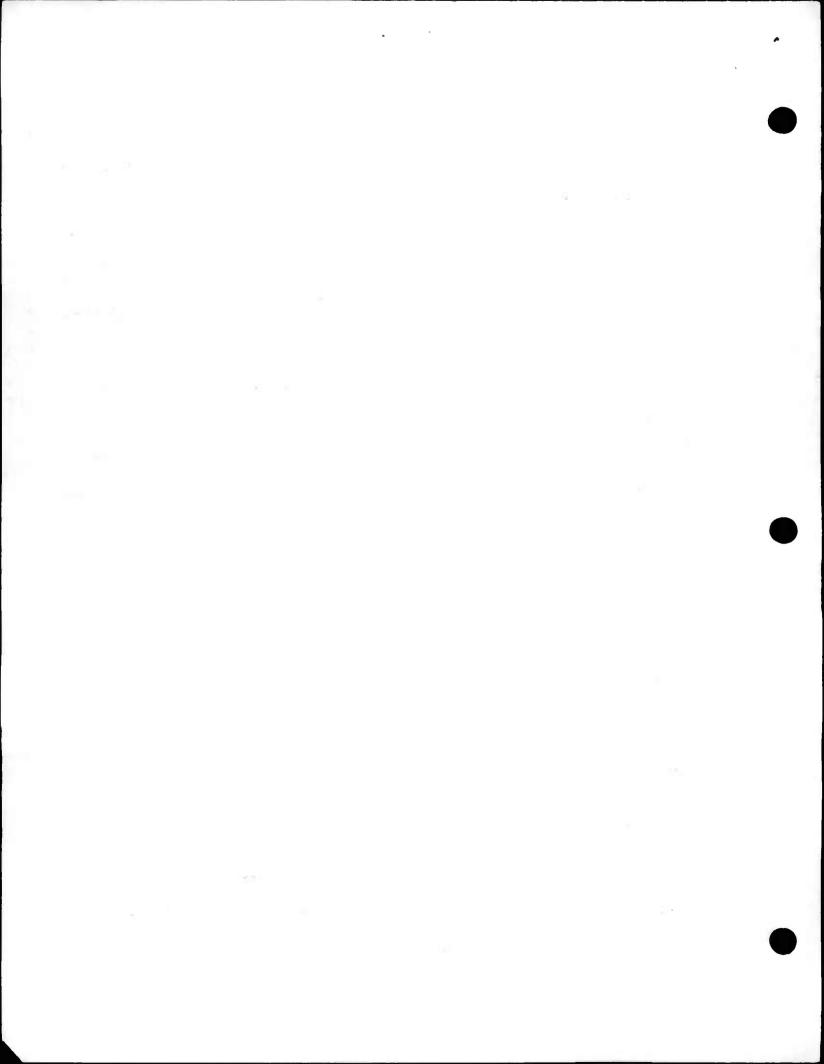
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hos TO THE FUNERAL OIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to feel of which the first pear. At the first certificate the first hand feel at the prior to burial, creation, or movel. | |
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| | | Low Land of Land | | | | | |
|--------------------|---|--|---|--------------------------------|--|---------------|---|
| | | | - | | | Q | 0 34193 |
| | 1 STATE | OF MARYLAND / DEPA | | | MENTAL HYGIEN | | 0 0-7130 |
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) | CERTI | FICATE OF | DEATH | REG. NO. | | 3. TIME OF DEATH |
| | | nosnia | | | DE LON | 1990 | AR |
| | 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birthday | MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| | 9. FACILITY NAME (If not institution, give street and nu | - 79 | 9b. CITY, TOWN OF | R LOCATION OF DE | C)ARCHar | 9c. COUNTY | OF DEATH |
| E C | 1709 B.T. SOGS | | Tows | 200 00 -00 | | BAL | Timore |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 100 | ITY, TOWN OR LOCATIO | | | | 10d, INSIDE CITY |
| DIR | MARYLAND BASTIC | JORE T | owson | | | | 1 YES 250 NO |
| FUNERAL | 10e. STREET AND NUMBER | - P | | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| JNE | 11. MARITAL STATUS 12. WAS | DECEDENT EVER IN U.S. ARMED | 13. WAS DECE | AIA31 | IC ORIGIN? (Specify Yes | or No 14. | RACE — American Indian. |
| B | 1 Never Merried 2 Merried FORG | ES? 1 YES 2 NO S, GIVE WAR OR DATES | If yes, spec | | n, Puerto Rican, etc.) | | RACE — American Indian, Black, White, atc. Specify: |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | (Give kind | 'S USUAL OCCUPATION of work done during mos use retired.) | N t of working | 16b. KIND OF BU | SINESS/INDUST | TRY |
| PLE | Elementary/Secondary (0-12) College | (1-4 or 5+) | THOM | | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | ME (First, Middle, Maiden | Surnama) | |
| BE | | Rasinb | 10 A B B B B B B B B B B B B B B B B B B | KAT | THERINS | Ui | GAAA |
| 5 | 190. INFORMANT'S NAME (Type/Print) FAMILY RECO | 205 | SAME | AS A | BOVE | | |
| | 20e, METHOD OF DISPOSITION 15 Burlel 2 Cremation 3 Removal from 4 Donation 5 Other (Specify) | | POSITION (Name of com | etery, crematory or | 20c. LO | CATION — CITY | or Town, Slate |
| | 21. SIGNOTURE OF FUNERAL SERVICE LICENSEE | 1,1200 L | - 400 | D ADDRESS OF FAC | SULTY OF C | Jewa | Riss |
| | balle of man | \ \hat{\tau} | 8800 | HARE | TORO ROA | 0 - P | arkville |
| | 23. PART 1. Enter the diseases, pr complices ehock, pr heert fellure. Liet pnly | Inna that caused the deeth. D | o not anter the mod | de of dying, suci | h ee cardlec or reep | retory erreat | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | | 25 | 0.00 | | | Onset end Deet |
| | resulting in death) e | DUE TO (OR AS A CONSEQUENCE | ECS | 11636 | オンド | | 7/2 |
| Z | C | | | | | | |
| ATION | Sequentially liet conditions, If any, leading to immediata cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE | OF): | | | | |
| FIC | CAUSE (Disease pr injury that initiated events | DUE TO (OR AS A CONSEQUENCE | OF): | | | | |
| CERTIFICA | reaulting in death) LAST | | | | | | |
| | PART II. Other significent conditione contrib | uting to death but not reculting | ng in the underlying | ceuse given in | Part i. 24s. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO |
| | DEHYDRATION | | | | 1 YES : | | COMPLETION OF CAUSE DF DEATH? |
| Ā | | | | | _ | | 1 NES 2 NO |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | | 26. PL | ACE OF DEATH (Ch | eck only one) | - | |
| SIC | EXAMINER? 1 YES 2 NO 1 Input | ITAL: itlent 2 ER/Outpatient 3 Do | OTHER: | 5 KReeldence | 8 Other (Specify) | | |
| PH | 27, MANNER OF DEATH 200 1 X Natural 5 Pending | DATE OF INJURY (Month, Day, Year) 28b. | TIME OF 28c, INJURY WO | RK? | 28d. DESCRIBE HOW | INJURY OCCUP | RED |
| B | 2 Accident Investigation | PLACE OF INJURY — At home, fer | | ES 2 NO | 281. LOCATION (Street | and Number or | Rural Route Number. |
| 밀 | 3 Suicide e Could not be 4 Homicide determined | building, etc. (Specify) | | | City or Town, State |) | |
| COMPLETED | CONSOR STRY | he best of my knowledge, death occubate of examination and/or investig | | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NUI | | | IGNED (Month, Day, Year) |
| TO BE | Jally Troub M. 30. NAME AND ADDRESS OF PERSON WHO COMPE | ETED CAUSE OF DEATH (ITEM 27) | Type, Print) | D93 | 86 | 30 ¢ | C11,1990 |
| | DR. SAMUL I. | | × 840 | s Lock | RAVER | BLI | 10. |

DHMH-18 Rev 1/89

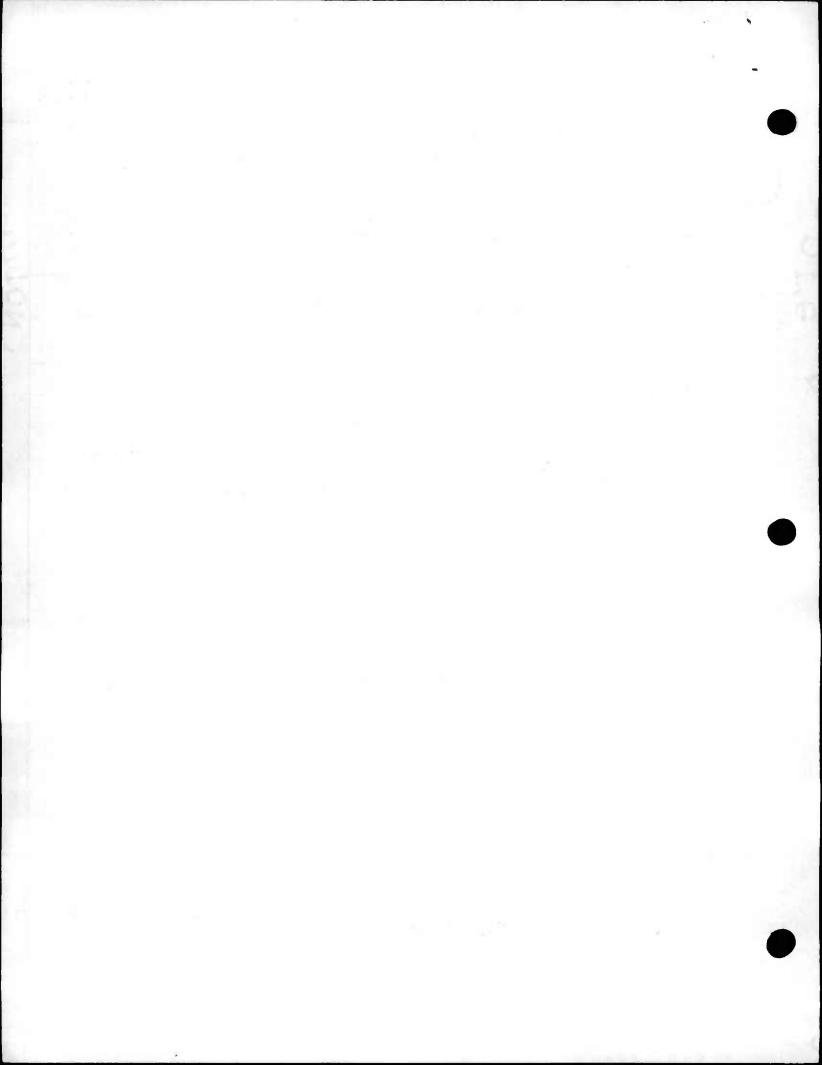
OCH RAVEN BLVD

DFC 1 3 1990



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| 13146, | The state of the s |
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| S, P.C | |
| CORD | |
| AL RE | |
| OF VI | |
| IVISION OF VITAL RECORDS, P.O. BOX 13146, | |
| 2 | 1 |

| | FOR STATE REGISTRAR | | STATE OF 1 | MARYLA | | | ENT OF I | | | IENTAL | REG. NO. | | 90 | 34194 |
|------------------------------------|--|--|--------------------|--|--|---|--|---|---|-----------------------------------|---|------------------|--------------------------------------|--|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE | OF DEATH | , | YEAR | 3. TIME OF OEATN |
| | | Jo | seph J | ulius | 3 | Re | omeo | | | 12 | 2-12-9 | 0 | | 4:19AM M |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AOE (In | n yrs. last bir | | UNDER 1 YEAR | HOURS | R 24 HRS. | 7. OATE (| OF BIRTN , Day, Year) | | 6. BIRTH Countr | PLACE (Stete or Foreign |
| | 198-22-434 | 10 | 1 M 2 F | 58 | YRS. 12-16- | | | | 2-16-3 | 1 | Pa. | | | |
| 11 | 90. FACILITY NAME (If not in | nstitution, give a | street end number) | | | 9b. | CITY, TOWN | | | | | 9c. COU | NTY OF D | EATH |
| OR O | St. Agnes | | ital | | | | Balt | Imor | e Cit | -y | | N/A | | |
| 당 | RESIDENCE OF DEC | 10b. COUNT | Υ | | 1 | Inc. CITY TO | WN OR LOCA | TION | | | | - | | 10d. INSIDE CITY |
| DIRECTOR | Md. | | e Arundel | | - 1 | | Burni | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | e Alunder | | | GIEII | | H. ZIP COD |)F | | | 10n, CIT | ZEN OF V | WHAT COUNTRY? |
| FUNERAL | 8913 Park | South | Dr. | | | | | 210 | | | | _ | J.S.A | |
| N N | 11. MARITAL STATUS | 50001 | 12. WAS DECEDER | IT EVER IN | U.S. ARME | D | 13. WAS DE | | | C ORIGIN | ? (Specify Yee | | | E — American Indian, k, White, etc. |
| | 1 Never Merried 2 2 | | FORCES? | | | | If yes, s | | en, Mexican | , Puerto F | | | Spec | |
| BY | 3 Widowed 4 Divo | orced | | -1950 | | | | | opromy. | | | | | White |
| COMPLETED | | CEDENT'S EDU | | | (Give | kind of work | AL OCCUPAT | ON ost of work | ing | 16b. | KIND OF BUS | INESS/IN | DUSTRY | |
| 191 | Elementary/Secondary (| 0-12) | College (1-4 or 5 | +) | | NOT use ret | | | | 1 | | | | |
| ₩ M | 12 | l | None | | Tech | nicia | an | | | | lesting | _ | se | |
| ဒ | 17. FATHER'S NAME (First, N | | | | | | | | | | Middle, Maiden | | | |
| BE | Samuel Rome | | | | | | | | | | Paletta | | | |
| 2 | 19e. INFORMANT'S NAME (| | | | _ | | | and Numbi | er or Rural R | loute Numb | ber, City or Town | n, State, Zij | D Code) | |
| | Frances E. | | | 000 | | ame as | - | | | | | | | SUSPECT STREET |
| | 1 Burial 2 Crematic | on 3 🗆 Rem | noval from State | | other place) | | | | | | | Crownsville, Md. | | |
| 5 | 4 □ Donetton 6 □ Other (Specify) Maryland Veterans Cemetery Crownsville, 21. SIGNATURE OF FUNERAL SÉRVICE LICENSES 22. NAME AND ADDRESS OF FACILITY | | | | | | | | s, riu. | | | | | |
| | . 90 | 4.5 | | | | | Sing | leto | n Fun | eral | Home | | | |
| 5 | 1 Second Ave. S.W. Glen Burnie, Md. 21061 | | | | | | | | | | | | | |
| 300 | | | | | | | | | | | Approximate interval Between | | | |
| | IMMEDIATE CAUSE (FI | | | | | | | | | | | | | Onset and Death |
| , | disease or condition | \rightarrow | Pulmonary emboli | | | | | | | | | | | |
| | | Due to (or as a consequence of): Deep venous thrombosis | | | | | | | | | | | | |
| | Sequentially list conditions. | | | | | | | | | | | | | |
| 16 | Sequentially ilst condit | tiona, | D. OUE TO | If any, leading to immediate | | | | | | | | | | |
| ATION | if any, leading to imme | diate | OUE TO | OR AS A | 001102001 | , | | | | | | | | İ |
| FICATION | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inju | ing | c | <u> </u> | CONSEQUI | ENCÉ OF): | | | | _ | | | | |
| RTIFICATION | if any, leading to imme cause. Enter UNDERLY | riNG ury | c | <u> </u> | | ENCE OF): | | | | | | | | |
| CERTIFICATION | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS | odiate VING ury | c | O (OR AS A | CONSEQUI | | | | | | | | | |
| ¥ | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust) that initiated events resulting in death) LAS | ediate VING ury ST conditio | c. OUE TO | O (OR AS A | CONSEQUI | uiting in t | _ | 10 | -50 | Part I. | 24a. WAS AN PERFOR | | 241 | D. WERE AUTOPSY FINDINGS AMILLABLE PRIOR TO |
| ¥ | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS | ediate VING ury ST conditio | c. OUE TO | O (OR AS A | CONSEQUI | uiting in t | _ | 10 | -50 | Part I. | 20000 | MED? | 248 | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust) that initiated events resulting in death) LAS | ediate VING ury ST conditio | c. OUE TO | O (OR AS A | CONSEQUI | uiting in t | _ | 10 | -50 | Part I. | PERFOR | MED? | 248 | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injusted interest in that initiated events resulting in death) LAS | ediate ing ing ing ing ing ing ing ing ing ing | c. OUE TO | O (OR AS A | CONSEQUI | uiting in t | se; Ob | esit | У | | PERFOR | MED? | 248 | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injusted interest in the cause of | ediate ing ing ing ing ing ing ing ing ing ing | d | o (or as a | ut not rea | diseas | se; Ob | esit | -50 | | PERFOR | MED? | 241 | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosci 25. WAS CASE REFERRED EXAMINER? XX YES 2 \(\) NO | ediate ing ing ing ing ing ing ing ing ing ing | d | death be ZASCII | ut not rea | diseas | 26. THER: | PLACE OF | DEATN (Che | ock only or | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosci 25. WAS CASE REFERRED EXAMINER? XX YES 2 \(\text{NO}\) 27. MANNER OF DEATN | ediate ing ing ing ing ing ing ing ing ing ing | d | death be ZASCII | ut not rea | diseas | 26. THER: Nursing No. F 28c. II | PLACE OF me 5 1 JURY AT | DEATN (Che | ock only or | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 \(\to \) NO 27. MANNER OF DEATN XX Natural 5 \(\to \) 2 \(\to \) Accident | ant condition | d | O (OR AS A O death bu VASCU VER/Outp F INJURY Day, Year) | ut not rea | DOA 4 | 26. THER: Nursing No. F 28c. II | PLACE OF me 5 1 JURY AT YORK? YES 2 | DEATN (Che | 6 Othe | PERFOR | NJURY OC | CCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sum \) NO |
| BY PHYSICIAN: MEDICAL | if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 \(\text{NO}\) 27. MANNER OF DEATN PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 \(\text{NO}\) 27. MANNER OF DEATN PART II. Other algnific 2 \(\text{NASCASE}\) Arteriosc 25. WAS CASE REFERRED EXAMINER? | ediate ing ing ing ing ing ing ing ing ing ing | d | o (or as a o death but a scale of | ut not rea | DOA 4 | 26. THER: Nursing No. F 28c. II | PLACE OF me 5 1 JURY AT YORK? YES 2 | DEATN (Che | eck only or 6 Other 28d, DE: | PERFOR | MED? | CCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sum \) NO |
| TED BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Entar UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XEYES 2 NO 27. MANNER OF DEATN YEN Accident 3 Suicide 6 4 Homicide | ant condition TO MEDICAL Pending Investigation conduction to be determined | d | O (OR AS A O death by VER/OUTP F INJURY Day, Year) OF INJURY OF INJURY OF INJURY | ut not rea | DOA 4 CONTROL OF THE | Z6. THER: Nursing No. F Z8c. II 1 28 | PLACE OF TIME 5 1 SURRY AT YORK? YES 2 | DEATN (Che | 28d, DE: | PERFOR YES 2 IN YES 2 IN (Specify) SCRIBE NOW 1 CATION (Street or Town, State) | NJURY OC | OCURED or or Rural | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 \(\sum \) NO |
| TED BY PHYSICIAN: MEDICAL | if any, leading to imme cause. Entar UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 NO 27. MANNER OF DEATN XX Natural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only) 1 CER | ant condition To MEDICAL Pending Investigation Could not be determined determined the physical condition of the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined the could not be determined to the could not be dete | d | Der/Outp | ut not rea | DOA 4 DOA 14 DOA TIME OF INJURY | Z6. THER: Nursing No F Z8c. II M 1 at, factory, off | PLACE OF me 5 1 SJURY AT YORK? YES 2 Ice | DEATN (Che Residence NO NO NO NO NO NO NO NO NO NO NO NO NO | eck only or 6 Other 28d, DE: | PERFOR YES 2 IN YES 2 IN (Specify) SCRIBE NOW I CATION (Street or fown, State) | NJURY OC | or or Rural | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Route Number, |
| TED BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust initiated events resulting in death) LAS PART II. Other aignific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 NO 27. MANNER OF DEATN WAS Natural 5 Carrier of the control of the control of the control of the control of the control of the control of the control of the cause o | ediate ring ury ST ant condition ant condition romeoical | d | Der/Outp | ut not rea | DOA 4 DOA 14 DOA TIME OF INJURY | Z6. THER: Nursing No F Z8c. II M 1 at, factory, off | PLACE OF THE 5 I I JURY AT YORK? YES 2 Ice | DEATN (Che Residence NO | 28d, DE: | PERFOR YES 2 IN YES 2 IN (Specify) SCRIBE NOW I CATION (Street or fown, State) | NJURY OC | or or Rural sted, | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Route Number, (e) and manner ee stated. |
| TED BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Entar UNDERLY CAUSE (Disease or inj that initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? 27. MANNER OF DEATN 27. MANNER OF DEATN 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER 1 CER (Check only one) 2 MET | ediate ring ury ST ant condition ant condition romeoical | d | Der/Outp | ut not rea | DOA 4 DOA 14 DOA TIME OF INJURY | Z6. THER: Nursing No F Z8c. II M 1 at, factory, off | PLACE OF THE 5 I I JURY AT YORK? YES 2 Ice | DEATN (Che Residence NO NO NO NO NO NO NO NO NO NO NO NO NO | 28d, DE: | PERFOR YES 2 IN YES 2 IN (Specify) SCRIBE NOW I CATION (Street or Town, State) use(e) end ma s end place, et | NJURY OC | er or Rural sted, the couse | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Rioute Number, (e) and manner ee stated. D (Month, Osy, Year) |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Entar UNDERLY CAUSE (Disease or injection in that initiated events resulting in death) LAS PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 NO 27. MANNER OF DEATN PART II. Other algnific Arteriosc 25. WAS CASE REFERRED EXAMINER? 27. MANNER OF DEATN PART II. Other algnific 28. CASE REFERRED EXAMINER? 29. Accident 3 Suicide 4 Homicide 29. CERTIFIER 1 CERTIFIER 29. MET 29. ASIGNATURE AND TITL | Pending Investigation Could not be determined extription Phys. Dical Examin | d | O (OR AS A O death by | ut not real lar of lar of lar of lar of lar of lar of lar of large, death in end/or triv | DOA of 4 (20b. TIME OI INJURY) e, farm, atree | 26. THER: Nursing No. F. 28c. If M. 1 | PLACE OF THE 5 I I JURY AT YORK? YES 2 Ice | DEATN (Che Residence NO NO NO NO NO NO NO NO NO NO NO NO NO | 28d, DE: | PERFOR YES 2 IN YES 2 IN (Specify) SCRIBE NOW I CATION (Street or Town, State) use(e) end ma s end place, et | NJURY OC | er or Rural sted, the couse | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Route Number, (e) and manner ee stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust initiated events resulting in death) LAS PART II. Other aignific Arteriosc 25. WAS CASE REFERRED EXAMINER? XX YES 2 NO 27. MANNER OF DEATN WAS Natural 5 Carrier of the control of the control of the control of the control of the control of the control of the control of the cause o | ant condition ant condition TO MEDICAL Pending Investigation Investigation of be determined determined E OP CERTIFIE DE PERSON W | d | O (OR AS A O death by | ut not real lar of lar of lar of lar of lar of lar of lar of large, death in end/or triv | DOA of 4 (20b. TIME OI INJURY) e, farm, atree | 26. THER: Nursing No F 28c, II M 1 st, factory, off In the time, da In my opinion, | PLACE OF me 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | DEATN (Che Residence NO NO Ce, end due rured at the | 261. LOC Chy to the ce time, date | PERFOR YES 2 THE PERFORMANCE OF TOWN, Street or Town, State) Buse(e) end ma e end place, en | NJURY OC | er or Rural sted, the couse TE SIGNE | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO Rioute Number, (e) and manner ee stated. D (Month, Osy, Year) |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x mours after death. Page 6 may be retained by the hospital or attending physician.

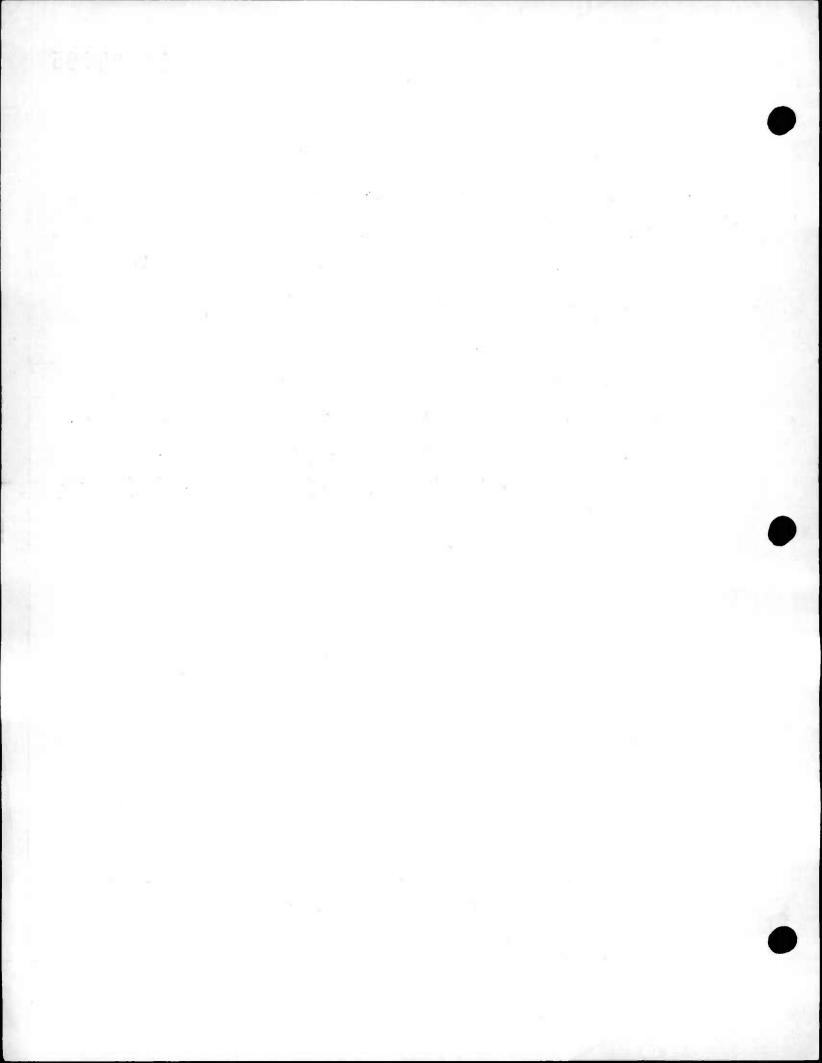
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to bunial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| R | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HY | GIENE |
|---------|--|--------|
| GISTRAR | CERTIFICATE OF DEATH REC | G. NO. |
| | | |

| 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | ENTAL HYGIEN | | | |
|--|--|---|-----------------|---|--|-------------------------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) ANNA | | RYI | AN | | MONTH 2 | | 3. TIME OF DEATH 3. TIME OF DEATH 3. TIME OF DEATH | |
| 220-22-9626 | 1 □ M 2 X) F 68 | YRS. MOI | UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 2/4/22 | м | BIRTHPLACE (State or Foreign Country) ARYLAND | |
| 9e. FACILITY NAME (If not institution, give street MERCY HOSPITAL RESIDENCE OF DECEDENT | et and number) | | | NORE CIT | | 9c. COUNTY | OF DEATH | |
| MERCY HOSPITAL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY MARYLAND | | | TIMORI | ON E CITY | | | 19d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| 100 E. 43RD ST 11. MARITAL STATUS | REET | | | ZIP CODE | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4XX ivorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | XXNO | 13. WAS DECI | ENDENT OF HISPANIC city Cuben, Mexican, 2 X NO Specify: | ORIGIN? (Specify Ye Puerto Rican, atc.) | | RACE — American Indian, Black, White, etc. Specify: | |
| 15. DECEDENT'S EDUCA (Specify only highest grade or | | 16e. DECEDENT'S USL (Give kind of work life. Do NOT use rel | done during mos | N It of working | 16b. KIND OF BU | JSINESS/INDUST | | |
| 17. FATHER'S NAME (First, Middle, Last) JOHN RYAN | | | | 18. MOTHER'S NAME VELM | E (First, Middle, Malder | Sumame) | | |
| 196. INFORMANT'S NAME (Type/Print) LOUISE JOHNSON | | | | nd Number or Rural Ro | | | , MD 21212 | |
| 20s. METHOD OF DISPOSITION 1A Burlel 2 Cremation 3 Remov 4 Donetton 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | IST ISEE | PEVENSON | LEROY 4600 | O ADDRESS OF FACILITY LIBERTY | EM. SP | N FUN | MARYLAND ERAL HOME NUE | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) | st only one cause on ee | ch line. | | | | | Approximate interval Between Onset and Death | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | CONSEQUENCE OF): | | | | | | |
| PART II. Other algnificent conditions | contributing to death bu | t not resulting in t | he underlying | cause given in Pr | | RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| | HOSPITAL: | T or | 26. PL THER: | ACE OF DEATH (Chec | k only one) | | | |
| | 28a. DATE OF INJURY (Month, Day, Year) | tient 3 DOA 4 [26b. TIME OF INJURY | F 28c. INJU | S Residence 6 IRY AT RK? ES 2 NO | Other (Specify) | INJURY OCCUR | ED | |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY - building, atc. (Specia | At home, farm, atree | | | 26f. LOCATION (Street City or Town, State | | Rural Route Number, | |
| | AN: To the best of my knowle | | | | | | suse(e) and menner as stated. | |
| TAZK. | rane | M.D. | | 29c. LICENSE NUMB | | | GNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO DOVALUS R. C | COMPLETED CAUSE OF DEA | | | St. PAY | IL PLACE | c, BA | H. MD. | |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | TURE A. OO. | | | | | | |





| | FOR STATE REGISTRAR | | STATE OF I | | D / DEPAR | | | | | MENT | AL HYGIEN REG. NO. | _ | | | 7150 | • |
|------------------|--|---|-------------------------|----------------------------------|------------------------------|------------------|----------|---------------|------------|-----------|--|------------|------------|---------|-------------------------------|-----|
| | 1, DECEDENT'S NAME (First, | Middle, Last) | | | | | | | | | TE OF DEATH | | WEAR | 3. TIM | ME OF DEATH | _ |
| | JOHN | A | Lbert | | S | CHNELL | | | | 12 | ити D/ 1.1 | | PRABY | ho. | 30 AM | М |
| | 4. SOCIAL SECURITY NUMB | IER | 5. SEX | 6. AGE (In yn | s. lest birthday) | IF UNDER 1 Y | EAR | IF UNDER | | | E OF BIRTH | 1 | 8. BIRTI | II LACL | (Otate or Fereign | n |
| | 218-34-2039 | 9 | 1 🔀 M 2 🗌 F | 8 | 4 YRS. | MONTHS D | MY8 | HOURS | MIN. | | -24-06 | | Mar | | nd | |
| | 9a. FACILITY NAME (If not in | | treet and number) | | | 9b. CITY, TO | OWN C | R LOCATI | ON OF DE | | 24 00 | 9c. COU | NTY OF D | _ | - III | |
| E C | NORTH ARUND | EL HOS | SPITAL AS | SCOCTA | TON | CIT | י זאי | DIIDM | T EZ | | | | | - | | |
| 5 | RESIDENCE OF DEC | EDENT | | DOULTA | | | | BURN | 1 11 | | | 1 | 1.A. | _ | UNTY | |
| H | 10a. STATE | 10b. COUNT | | | | TY, TOWN OR | | | | | | | | 10d. i | NSIDE CITY | |
| | Md. | Anne | Arundel | | G. | len Bu | 7 | - | | | | | | | YES 2 X NO | |
| ¥ | 10e. STREET AND NUMBER | | | | | | 101 | ZIP COD | E | | | 10g. CITI | ZEN OF | WHAT C | OUNTRY? | |
| FUNERAL DIRECTOR | North Arun | del. (| 7 | | | | | 21061 | | | | | S.A. | | | |
| 5 | 11. MARITAL STATUS 1 X Never Married 2 | | 12. WAS DECEDED FORCES? | T EVER IN U.S | K NO | | | | | | GIN? (Specify Yes to Rican, etc.) | or No- | 14. RACI | E — An | nericen indien, e, etc. | |
| BY | 3 Widowed 4 Divo | | IF YES, GIVE | | | | | 2 🖄 NO | | | | | Spec | , | | |
| | | EDENT'S EDU | CATION | 40. | . DECEDENT'S | | | | | | 16b. KIND OF BU | | | Whi | .te | |
| 1 | (Specify only | y highest grade | completed) | | (Give kind of life. Do NOT u | work done dur | ing mo | st of working | ng | - 1. | IBB. KIND OF BU | SINESS/INL | JUSTRY | | | |
| 7 | Elementery/Secondery (0 |)-12) | College (1-4 or 5 | | Sales | 100.00.7 | | | | - 1 | Self E | mplos | , od | | | |
| COMPLETED | 17. FATHER'S NAME (First, M | licidle (net) | NO | | Jares | | - | 40 1407 | HED'S NA | ME /EI- | st, Middle, Maiden | ~ | eu | | | |
| | John Schne | | | | | | | | | | Felix | Sumeme) | | | | |
| BE | 190. INFORMANT'S NAME (7 | | | | 105 11411 101 | O ADDRESS (| Da 4 . | | | | umber, City or Tow | - 0 7 | 0-4-1 | | | _ |
| 2 | Bertha L. S | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | | | | | | | | |) | | |
| | | | | 20h Bi | ACE OF DISPO | | | | | rasa | adena, | CATION - | | | | |
| | 20e, METHOD OF DISPOSIT 1 Burlei 2 Cremetto | | oval from State | oth | ner place) | etro C | | | | | | tonsv | | | | |
| | 4 Donation 5 Other 21. SIGNATURE OF FUNERA | | CENSEE | 1 | LI | | | ND ADDRE | | CILITY | | LUIISV | TTT | -, 1 | au. | _ |
| | AM | 000 | BI | ins. | ne | / S | ing | gleto | on Fi | unei | ral Home | | rnie | Mc | 1.21061 | |
| | 23. PART I. Enter the d | | | | | | | | | | | | | | Approximeta | - |
| | | | List only one ca | use on each | line. | | | | | | | | | i | Interval Betw Oneet and De | |
| | IMMEDIATE CAUSE (Fir disease or condition | 101 | C | 10 | | 1Ru | | | | | | | | į. | ? Yrs | |
| | resulting in death) | 7 × 1 | e -ous-n | drom | HOCOUENCE | | | | | | | | | Ť | . // L | _ |
| | | - | M | 1 | 200 | 0 | 00 | II. | | | | | | İ | | |
| CERTIFICATION | Sequentielly list condit | | DUE TO | O (OR AS A CO | NSEQUENCE (| | | ، عادلت | | | | | | - | | |
| XT. | cause. Enter UNDERLY | ING | De | John to | 0 | Mee | | | | | | | | - ! | | |
| Ĕ | CAUSE (Disease or injution that initiated events | IIV | DUE TO | O (OR AS A CO | NSEOUENCE (| OF): | | | | | | | | _ | | |
| H | reaulting in death) LAS | T | a and | extro. | $\overline{}$ | | | 4. | | | | | | - | | |
| 2 | 24.57 H OH I - H | | | | | | | | | | 1 (2) | | 1. | | | |
| AL | PART II. Other algolitica | | na contributing t | o death but | not resulting | in the unde | erlyin | g ceuse | given in | Part I. | 24a. WAS AN | | 24 | AWAIL | ABLE PRIOR TO | |
| 50 | 1º all milly | | | | | | | | | _ | 1 TYES | NO NO | | | PLETION OF CAUS EATH? | 3E |
| MEDIC | Derubert. | is l | Meer | | | | | | | | 1 | | | 1 📋 | YES 2 NO | |
| ä | Intect | an | | | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED T | O MEDICAL | HOSPITAL: | | | OTHER: | 26. P | LACE OF I | DEATH (Ch | neck only | y one) | | | | | |
| YSI | 1 TES 2 NO | | 1 Inpatient 2 | ☐ ER/Outpatie | nt 3 🗆 DOA | | ng Hon | ne 5 🗆 R | esidence | 6 🗆 0 | ther (Specify) | | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | | 26a. DATE O (Month, | F INJURY Day, Year) | 26b. Ti | ME OF 2 | 8c. IN. | JURY AT | _ | 26d. | DESCRIBE HOW | INJURY OC | CURED | | | |
| ВУ | 1 (Natural 5 2 Accident | Pending Investigation | _ | | | | 1 🗌 | YES 2 | NO NO | | | | | | | |
| | 3 Suicide 6 | Could not be | 26e, PLACE building | OF INJURY — j, etc. (Specify) | At home, farm | , street, factor | y, offic | ie e | | | OCATION (Street City or Town, State | | r or Rural | Route I | Number, | |
| TE | 4 Homicide | determined | | | | | | | | | | | | | | |
| PLE | 29a. CERTIFIER (Check only | TIFYING PHYS | ICIAN: To the best | of my knowledg | ge, death occu | rred at the tim | e, date | end plac | e, end due | e to the | cause(s) end ma | nner as st | sted. | | | |
| COMPLETED | 41 | | ER: On the basis of | | | | | | | | | | | (e) and | manner as state | ed. |
| E C | 296. SIGNATURE AND TITLE | E OF CERTIFIE | J ₂ | | | | | 29c. LIC | ENSE NU | MBER | | 29d. DAT | TE SIGNE | D (Mont | th, Day, Year) | |
| 0 | Dunil | RA | 20.00 | _ m | D | | | | 35 | | 14 | | | | 1990 | |
| 2 | 30 NAME AND ADDRESS O | E DEDCON W | UP ON OU ETED CA | ISE OF DEATH | OTEM OD /S- | no Delecti | _ | | ~ U | 0 (| 1 | | • | - / | 11- | _ |

#203/GLEN BURNIE.



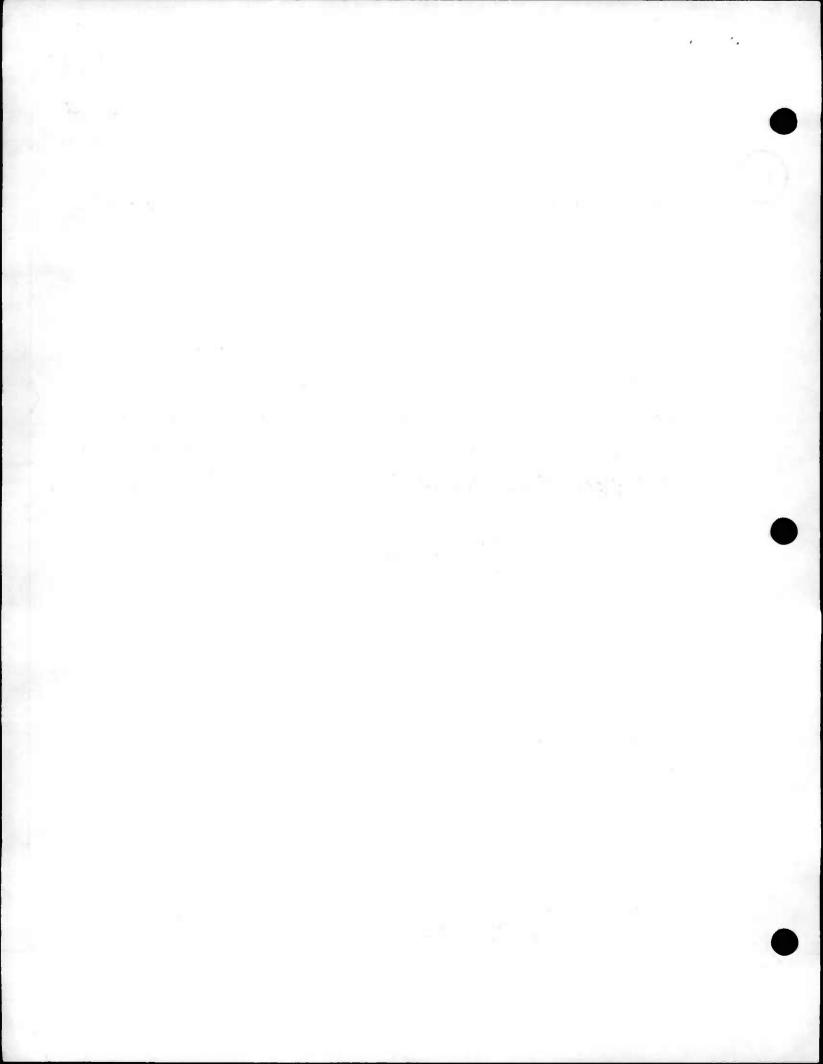
30. NAME AND ADD

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DEC 1 3 1990

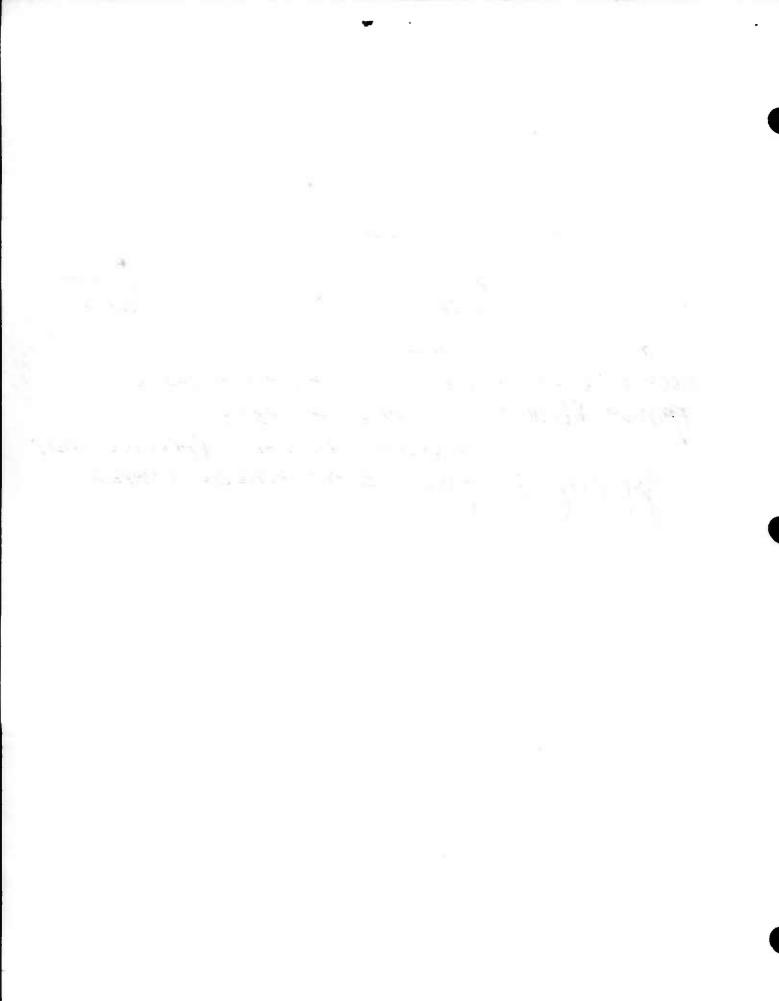
M.D./95

AQUAHART ROAD,



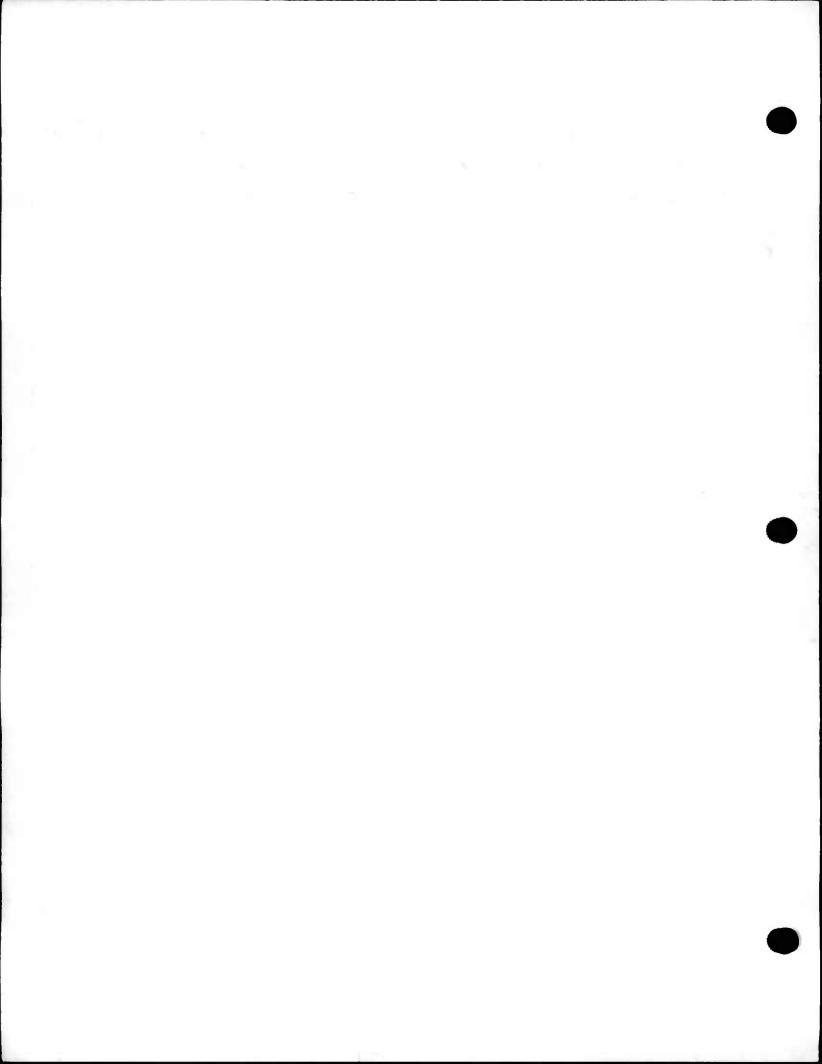
| ysician. | ırial-trans | |
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| id Buildie |) THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
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| ay be retained by the nospital | 5 shou | notifie |
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| The law requires that the death certificate of executed with | the a | inim |
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| OSP | UNER | S. S. P. P. |
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| | FOR STATE REGISTRAR | STATE OF MARYLANI | D / DEPARTA | MENT OF H | EALTH AND I DEATH | MENTAL HYGIENE REG. NO. | | | | |
|--------------------|--|---|---|---------------------|-----------------------------|--|----------------------|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | J. Schult | e | | | 2. DATE OF DEATH MONTH DAY | GO STEAM | 3. TIME OF DEATH | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs | " - | UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 20 8. BIR Coun | THPLACE (State or Foreign ntry) MD | | |
| TOR | 98. FACILITY NAME (If not institution, give stress of the property of the prop | 05014W 1205 YU | | Tause | n LOCATION OF DE | АТН | 9c. COUNTY OF | DEATH . | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | Llt | 10c. CITY 1 | TOWN OR LOCAT | Balt. | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| FUNERAL | 3008 Moreland | Ave | | 101 | 21234 | | 10g. CITIZEN OF | WHAT COUNTRY? | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S FORCES? 1 17 YES 2 IF YES, GIVE WAR OR DATES | □ NO | If yes, sp | | IIC ORIGIN? (Specify Yee on, Puerto Rican, atc.) | or No— 14. RA Spi | CE — American malen, ack, While, etc. | | |
| COMPLETED | 15, DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12) | | DECEDENT'S US (Give kind of word life. Do NOT use n | k done durina mo | N st of working | 16b. KIND OF BUSI | NESS/INDUSTRY | | | |
| СОМР | 17. FATHER'S NAME (First, Middle, Last) | 24 SCHULTE | 111430 | // | 18. MOTHER'S NA | ME (First, Middle, Maiden S | AHIU | | | |
| TO BE | 198 INFORMANT'S NAME (Type/Prings) | CORDS | _ | DDRESS (Speet a | nd Number or Rural I | Poute Number, City or Town | , State, Zip Code) | | | |
| | THOO OF DISPOSITION THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS COMMON THURS | | ACE OF DISPOSITI | ON (Name of cer | etery, crematory or | AL PA | ATION — CITY OF | LE, MD, | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | J. Ga | ir | EVA. | D ADDRESS OF EA | INERAL | - CHA | PEL | | |
| | 23. PART Enter the diseases, of canonic shorts, or beart failure. I iMMEDIATE CAUSE (Final disease or condition resulting in daeth) | omplications that caused the list only one cause on each a mutasta. DUE TO (OR AS A CO | tic (| <i>-</i> 0 . | de of dying, suc | | atory arrest, | Approximate interval Between Onset and Death | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avanta DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | resulting in deeth) LAST | | | Ab d . d . d . d | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions | i contributing to deeth but i | not resulting in | the underlyin | g cause given in | Part I. 24a. WAS AN / PERFORI 1 TYES 2 | MED? | Ab. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 20.00 | ACE OF DEATH (Ch | | | | | |
| SICI | EXAMINER? | HOSPITAL: | | THER: | | 6 Other (Specify) | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME (| OF 28c. IN. | | 28d. DESCRIBE HOW IN | JURY OCCURED | | | |
| | 3 Suicide & Could not ba | 28e. PLACE OF INJURY — building, etc. (Specify) | Al home, farm, atr | eel, factory, offic | • | 281. LOCATION (Street a City or Town, State) | nd Number or Run | al Route Number, | | |
| COMPLETED | (0/100/1 0/1/) | CIAN: To the best of my knowledge. R: On the basis of examination en | | | | | | se(e) end menner ee stated. | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIER Realing | ? Origon | v.N. | p. D. | 29c. LICENSE NUI | MBER 492 | 29d. DATE SIGN | IED (Month, Day, Year) | | |
| | BEATRIZ | COMPLETED CAUSE OF DEATH | (ITEM 27) (Type, P | St. G | Dright | Hazita | El Va | Ecoson mol | | |
| - | 31. DATE DE C 1 3 1990 | A PURE DE TRANSPORTE | AR SE | V | , | | | | | |



FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. NO. | | |
|--|--|---|---------------------------|--------------------------------|---|----------------------|---|
| 1. OECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH | YEAR 90 | 3. TIME OF DEATH |
| Robert Le 4. SOCIAL SECURITY NUMBER 216 - 40 - 0769 | 5. SEX 6. AG | E (In yrs. last birthday) | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 6. BIFF Cour | THPLACE (State or Foreign ntry) |
| 98. FACILITY NAME (If not institution, give st | KEY ME | 1 ctr. | A 11 | NORE, | | Bal 6 | DEATH |
| 10e. STATE 10b. COUNTY | , | | timor | | | | 10d. thside city LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER | | Dai | 10f | ZIP CODE | | | WHAT COUNTRY? |
| 5034 West Hill 11. MARITAL STATUS 1 Never Married 2 XX Marriad 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 XNO | 13. WAS DEC | | IIC ORIGIN? (Specify Yearn, Puarto Rican, atc.) | or No- 14. RA Ble | CE — American Indian, ack, White, atc. |
| 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDENT'S US (Give kind of wor life. Do NOT use i | k done during mo- | N al of working | 16b. KIND OF BU | SINESS/INDUSTRY | Black |
| 12th Grade 17. FATHER'S NAME (First, Middle, Last) | College (1-4 or 5+) | Fork Li | | | Ca | | Distillery |
| Robert Lee Sam | ple, Sr. | | | | le Thoma | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | ODRESS (Street a | nd Number or Rural | Route Number, City or Tow | n, State, Zip Code) | 21229 |
| Betty Sample | | | | | ¥ T | | Maryland |
| 20e. METHOD OF DISPOSITION 1X Burlet 2 Cremation 3 Remarks | oval from State | 20b. PLACE OF DISPOSIT other place) | | netery, crematory or | | CATION — City or | |
| 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE / | Loudon F | | D ADDRESS OF FA | | | e, Marylar |
| · bay x | . Loll | us | | | s Falls Marylan | | ral Homes |
| Sequentially list conditions, | a. Pancerea DUE TO (OR A | , | ANCEI | | | | Interval Betwee |
| If any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | S A CONSEQUENCE OF): | | | | | |
| PART II. Other significant condition | s contributing to deet | but not resulting in | the underlyin | g ceuse given in | Part I. 24a. WAS AN PERFO | RMEO? | 4b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 PONO |
| 25. WAS CASE REFERRED TO MEOICAL EXAMINER? | | | | ACE OF DEATH (C) | eck only one) | | |
| 1 TYES 2 NO | HOSPITAL: 1 Inpatient 2 ER/0 | | OTHER: | e 5 🗆 Residence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH 1 Naturat 5 Pending 2 Accident trivestigation | 28s. DATE OF INJUR (Month, Day, Yes | | Y WC | URY AT RK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | |
| 3 Suicide 6 Could not be 4 Homtcide detarmined | 28e. PLACE OF INJU- building, etc. (S | JRY — At home, farm, stri Specify) | est, factory, offic | | 26f. LOCATION (Street City or Town, State | | el Route Number, |
| Torroom only | ICTAN: To the best of my kn | | | | | | e(s) and manner as stated. |
| 29h, ASDHATURE AND TITLE OF CERTIFIE | - MO | | | 29c. LICENSE NU | MBER 371 | 29d. DATE SIGN ► Z | ED (Month, Day, Year) |
| 30. NAME AND ADDRESS & PERSON WH | M O 10 COMPLETED CAUSE OF 32 MEGISTRAR'S | | rint) | D403 | 371 | 126 | 190 |



BE CON

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STATE HOSE

ECTOR: After this certificate has been supred by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should if them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ATTENDING PHYSICIAN: The law inquires that the death certificate be executed within

| | FOR 1 - STATE REGISTRAR | STATE OF M | MARYLAND C | / DEPAR | | | | | | HYGIEN REG. NO | _ | 90 | 34199 | |
|------------------|---|---------------------------|---------------------------------------|------------------------------|--|------------------|-------------|------------|--------------|---------------------------|-------------------------------|---------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATH | | | 3. TIME OF DEATH | |
| | Joe Allen | Sano | ders | | | | | | Dec. | 9, | 199 | YEAR | 17:77011 | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | ast birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF | | 100 | | PLACE (State or Foreign | |
| | 0.47 00 5050 | 1 🖟 M 2 🗆 F | | wne | MONTHS | DAYS | HOURS | MIN. | (Month, E | lay, Ybar) | | Country |) | |
| | 247-22-5359 | A | 6 | 8 | | | | | 11/0 | 9/19 | | Carolina | | |
| ~ | 9a. FACILITY NAME (If not institution, give at | reet and number) | | | 9b. CITY | , TOWN O | R LOCATIO | ON OF DEA | ATH | | 9c. COU | NTY OF DE | ATH | |
| Ö | 6741 Ransome I | rive | | | Ва | lti | more | е | | | | | | |
| 5 | | | | | | | | | | | | | | |
| 2 | | | | 1116/03/24 | Y, TOWN C | | ann- | | | | | - 1 | 10d. INSIDE CITY LIMITS? | |
| | Maryland | | | B | alti | mor | e | | | | | | 1 XYES 2 NO | |
| 4 | 10e. STREET AND NUMBER | | | | | 101. | ZIP CODE | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| 뚭 | 6741 Ransome | Drive | | | | 1 2 | 120 | 7 | | | U. | . S. A. | | |
| FUNERAL DIRECTOR | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. A | RMED | 13. | WAS DECE | NDENT O | F HISPANI | C ORIGIN? (| Specify Ye | a or No- | | - American Indian, | |
| | 1 Never Married 2 Married | FORCES? T | YYES 2 WAR OR DATES | NO | | | cify Cubar | n, Mexican | , Puerto Ric | | | Black, | White, etc. | |
| _ 6 | 3 Widowed 4 Divorced | 17 120, 0112 1 | WIT ON DATES | | | 1 153 | 2 110 | Specify. | | | Specify: Black | | | |
| | 15. DECEDENT'S EDUCATION 16a. OECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY | | | | | | | | | | Diack | | | |
| | (Specify only highest grade | College (1-4 or 5 | | Give kind of le. Do NOT u | of work done during most of working Tuse retired.) | | | | | | | | | |
| 1 2 1 | Elementary/Secondary (0-12) | | 211 | Uand | llor | | | | C | Dog | + - 1 | Corrido | | |
| COMPLETED | Mail Handler U.S. Postal Service 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meldlen Surname) | | | | | | | | | | | service | | |
| 8 | | | | | | | | | | | | | | |
| 띪 | Jimmy Sanders Ella Cheesebaro 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2020/ | | | | | | | | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILING | ADORESS | S (Street ar | nd Number | or Rural A | oute Number, | City or Tox | vn, State, Zij | o Code) | 29204 | |
| | Rudy Canzater | | | 2371 | Cen | nter | n St | t. C | colum | bia, | , So | uth | Carolina | |
| | 20g METHOD OF DISPOSITION | | 20b. PLACE | E OF DISPO | SITION (Na | ume of cem | etery, crem | entory or | | 20c. LC | CATION - | City or Tov | vn, Stata | |
| | 1 X Burial 2 Cremation 3 Remo | oval from State | Cres | sent. | Hil | 1 Me | -m- | Gar | dens | Co | lumb | nia. | S Carolin | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | 10101 | 70110 | 22. | NAME AN | D ADDRES | SS OF FAC | LITY MII | ++01 | Fil | nora | 1 Homes, | |
| | N. 100 - 11 | 2 D | Λ | | | | | | Fal | | | | I Homes, | |
| | Vernon | Co De | vely | | É | Balt | imoi | re, | Mary | land | 1 2 | 1216 | | |
| | 23. PART I. Enter the diseases, or of shock, or heart fellure. | omplications the | t caused the d | leath. Do | not enter | the mod | de of dyl | ng, such | ea cardle | c or reap | iratory ar | rest, | Approximate | |
| | IMMEDIATE CAUSE (Finel | List only one cat | ase on each in | 10. | | | | | | | | | Interval Between Onset end Death | |
| | disease or condition | Pila | | | 1 | | | | | | | | 1 1 5 | |
| | resulting in death) | Pu.h | LOB AS A CONS | EQUENCE O | D- | | | | | | | | , without the | |
| | | | | | | | | | | | | | | |
| 8 | Sequentially list conditions, | Due To | OR AS A CONS | Cen | -C.han | ~~ | | | | | | | 6 muth | |
| Ē | if any, leading to immediate | DOE 10 | (OR AS A CONSI | EGUENCE U | 1-): | | | | | | | | | |
| 0 | CAUSE (Disease or Injury | Lon | | | | | | | | | | | 6 renth | |
| 별 | that initiated events | DUE TO | ON AS A CONSI | EQUENCE O | F): | | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | 1. | | | | | | | | | | | | |
| O | PART II. Other significant condition | a contribution to | doub but not | | In the sec | 4.4. | | | · I - | | | 1 | | |
| ₹ | 4. | | death but not | _ | | naeriying | cause g | jiven in i | Part I. 2 | PERFO | | 24b. | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| ۱ă۱ | - Chymi 6 5 5true | The july | ~ | dsu | ~~ | | | | 1 | YES : | 2 D.NO | | COMPLETION DF CAUSE OF DEATH? | |
| MEDICA | | | | 7 | | | | | _ | | | - 1 | 1 YES 2 NO | |
| 3 | | | | | | | | | _ | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PL | ACE OF D | EATH (Che | ck only one) | | | | | |
| 잃 | EXAMINER? | HOSPITAL: | T ED (Outrositors | • [] poe | OTHE | R: | | , | | | | | | |
| ž | 27. MANNER OF DEATH | 1 Inpetient 2 | | - | | | | sidence | 6 Other (| | DI 01500 C | www. | | |
| å | 1 Natural 5 Pending | (Month, E | | 28b. TIR | JURY JURY | 28c. INJU WOI | RK? | | 28d. DESCI | INSE HOW | INJURY OC | CURED | | |
| à | 2 Accident Investigation | | | | M | | ES 2 | J №0 | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE (building, | OF INJURY — At It off, etc. (Specify) | nome, ferm, | street, faci | tory, office |) | | 28f. LOCAT | ON (Street Town, State | and Numbe | or or Rural R | oute Number, | |
| ETED | 4 Homicide determined | | | | | | | | | | | | | |
| 3 | 29a. CERTIFIER | CIAN: To the heet of | l mu limenila des la | death assur | | | | er a arc | | 400 | | | | |

29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

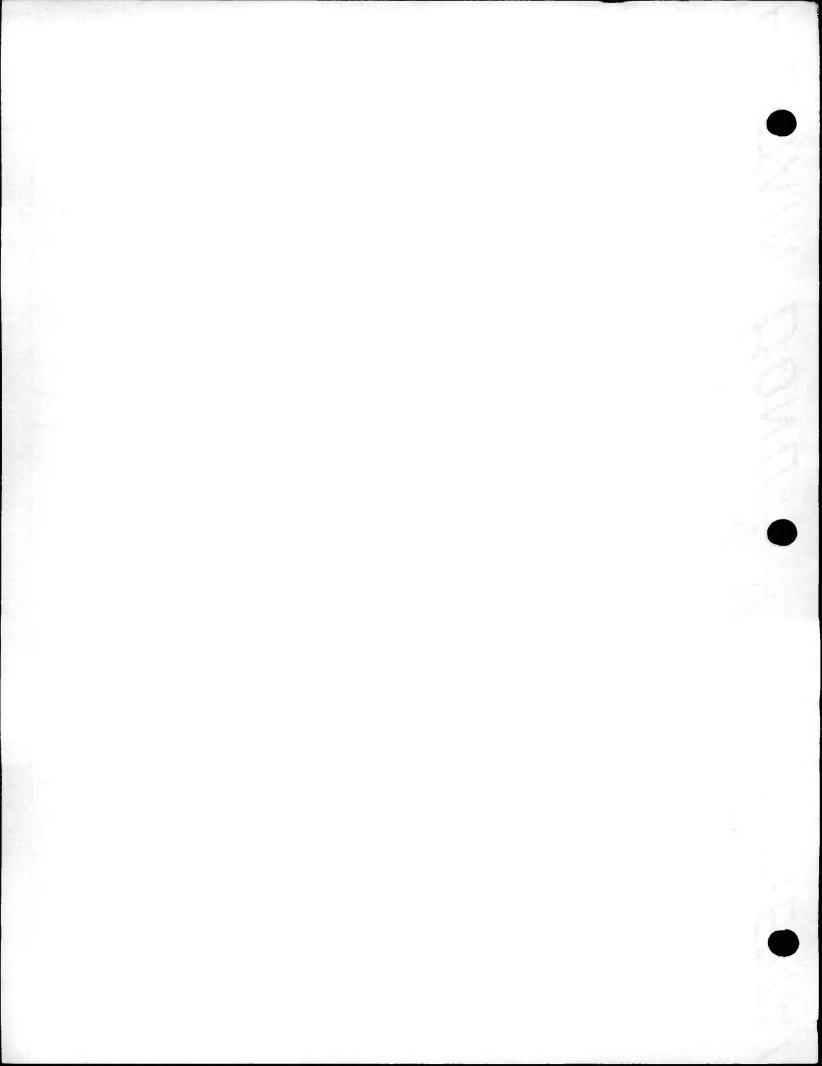
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York Son med 2/2 04 10u

1990

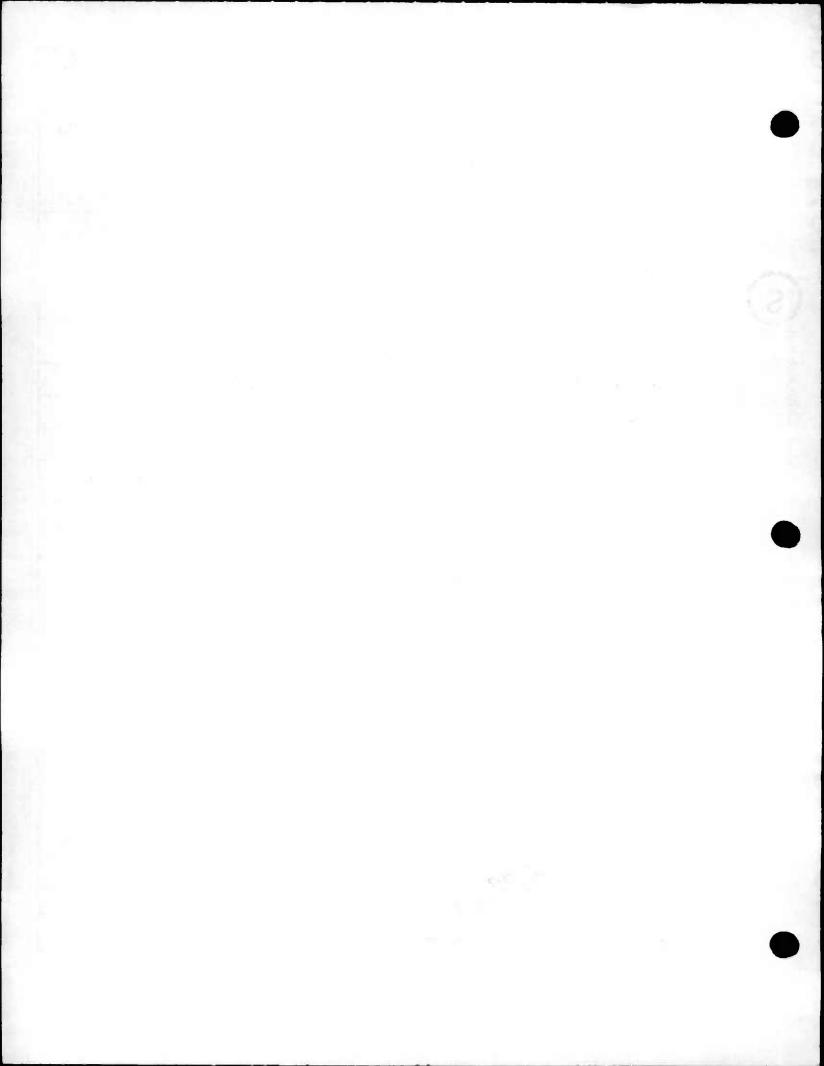
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | ne lav | has Dep | п 23 |
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| | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within dars after death. Page 6 may be retained by the hospital or attributed in the control of the propriation of the propria | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use at the hardal be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | | | |

sit permit. Pages 1, 2, 3 should

| | 1 - FOR STATE REGISTRAR | STATE OF MARY | | | OF HEALTH AND | MENTAL HYGIEN | | | | |
|-----------------|---|---|--------------------------------------|--|---|---|----------------|---|--|--|
| | | ECOR | ROTHY AND | SECOR | | | AY YEA | 3. TIME OF DEATH, | | |
| | 4. SOCIAL SECURITY NUMBER 579 34 4399 | 1 🗆 M 2 🖫 🗲 | GE (In yrs. lest birthde) 62 YRS. | MONTHS C | AYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Sept. 22, | 1928 Ñ | RTHPLACE (State or Foreign Suntry) ID | | |
| TOR | 9a. FACILITY NAME (If not institution, give st Sowhen Mprey RESIDENCE OF DECEDENT | treet and number) | ch | | own or location of o inton | EATH | Prince garges | | | |
| DIRECTOR | 100. STATE 10b. COUNTY MD Prin | ce George's | | per Ma | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | |
| | 100. STREET AND NUMBER 9314 Croom Rd. | | | | 101. ZIP CODE 20772 | | 10g. CITIZEN O | OF WHAT COUNTRY? | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Olvorced | 12. WAS DECEDENT EVE FORCES? 1 YOUR WAR OF | ES 2 NO | 13. WA If y 1 | ACE — American Indian, Black, White, atc. | | | | | |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondery (0-12) 1.2 | | (Give kind o | CEDENT'S USUAL OCCUPATION The kind of work done during most of working Do NOT use retired.) housewife | | | | | | |
| BE COI | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Melden Surname) Mabel Isabelle Hall | | | | | | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thornton H. Secor same as 10 above | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 XX Burlel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Harmony UM Church Ce | | | | | | ngs (Ca | r Town, Stata 1vert) MD | | |
| | 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD 20736 | | | | | | | | | |
| CERTIFICATION | 23. PÄRT I. Enter the diseesa, or cahock, or heert feilure. IMMEDIATE CAUSE (Final diseese or condition resulting in death) Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Acute DUE TO (OR A DUE TO (OR A | n each line. | of: CANCIOFI | | | | Approximate Interval Batween Onset and Death | | |
| CAL | PART II. Other algnificent condition | a contributing to deat | h but not reaultin | g in the unde | arlying couse given in | Part I. 24a. WAS AI PERFO | RMED? | 24b. WER AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| HAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | 26. PLACE OF DEATH (C | heck only one) | | | | |
| PHYSICIAN: MEDI | 1 YES 2 NO 27. MANNER OF CEATH 1 Natural 5 Pending | 1 Inpatient 2 ER/C 28a. DATE OF INJU (Month, Day, Yel | RY 28b. 1 | IME OF 2 | g Home 5 Residence Bc. INJURY AT WORK? 1 YES 2 NO | 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCURE | D | | |
| TED BY | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJ building, atc. (| URY — At home, farm Specify) | | | 281. LOCATION (Street City or Town, State | | iral Route Number, | | |
| COMPLETED | ana) | ICIAN: To the best of my k | | | | | | rse(e) end manner ee stated. | | |
| TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIES LIVER LIVE 30. NAME AND ADDRESS OF PERSON WH | R R C S C C C C C C C C C C C | DEATH STEEL ON CT | - 040 | 29c. LICENSE NU | MBER 62 | 29d. DATE SIG | NED (Month, Day, Year) | | |
| | INDA Whithy | 32. REGISTRAR'S S | 1556 0 | RAIN | thoy | Upper m | mella | o hes 20772 | | |
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| | PITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 27 NOUNS after deal | and the second s |
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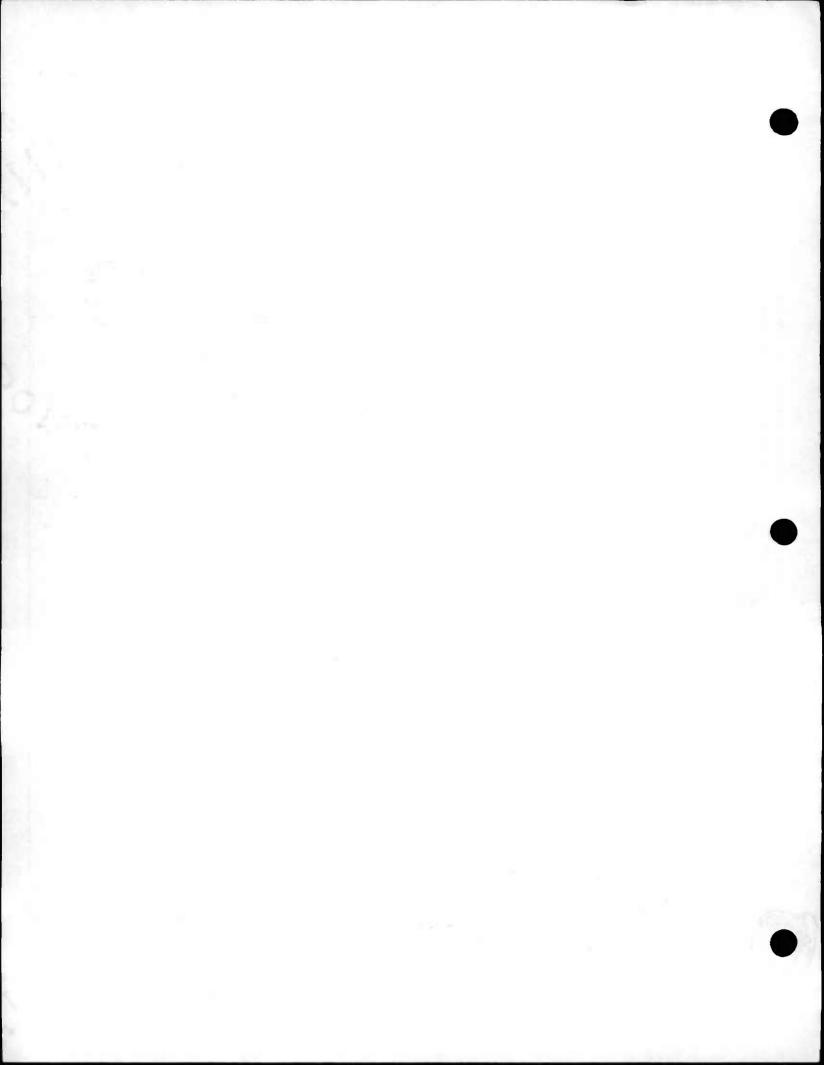
| _ | REGISTRAR | | | | OFILL | IVAIL | . 01 | DEA | | | EG. NO. | | | |
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| | 1. DECEDENT'S NAME (First, | | 4 | | | | | | | 2. DATE OF E | DATH DA | | YEAR | TIME OF DEATH |
| | Jud | | A | | | Sikor | | T | | 12 | 7 | | 90 | 7:00 P. M |
| | 4. SOCIAL SECURITY NUMBER 124-20-56 | | 5. SEX | | n yrs. last birthday) | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF B (Month, Day | (Year) | | Country) | ACE (State or Foreign |
| | | | 1 🗆 M 2 💢 F | 63 | YRS. | | | | | 2-18 | 3-19 | | | York |
| ~ | 9e. FACILITY NAME (If not in | | 500 | | | 9b. CITY, | | OR LOCATION | | ATH | | 9c. COUN | TY OF D | • |
| 5 | 1206 W. | | ern Parkw | ay | | | В | altim | ore | | | | _ | |
| DIRECTOR | 10e. STATE | 10b. COUNT | Υ | | 10c. CIT | CITY, TOWN OR LOCATION 10d. INSIDE C | | | | | Dd. INSIDE CITY LIM!TS? | | | |
| a | Maryland | | | | | Balt | im | ore | | | | | 5 | YES 2 NO |
| A | 10e. STREET AND NUMBER | | | | | | - | or. ZIP CODE | E | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| FUNERAL | 1206 W. N | Vorth | | | | o, M | ld. | 21 | 209 | | U.S.A. | | | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDED | NT EVER IN | U.S. ARMED | | | | | HC ORIGIN? (Sen, Puerto Ricar | | or No- | | - American Indian, White, atc. |
| BY | 1 Never Merried 2 Never Merried 2 Divo | rced | IF YES, GIVE | | | | | S 2 XNO | | * | | | Specify: | White |
| LETED | | EDENT'S EDU y highest grade | | | 16a. DECEDENT'S | work done of | | | ng | 18b. KIN | D OF BUS | SINESS/INDU | JSTRY | |
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| COMP | Unkn | | | | Seam | stre | SS | T 40 1-0- | ucow | ME /C: 102 * | | ing | | |
| | | HUGHR, LAIST) | | | | | | 18, MOT | | ME (First, Middle | | ourname) | | |
| BE | Unknown 199, INFORMANT'S NAME (1 | Type/Print) | | | 19b. MAII IN | G ADDRESS | (Street | and Number | | nknown Boute Number, C | | n State 7in | Code) | |
| 2 | Mr. John | ,, | 5 | | | | | | | | | | | Md 21229 |
| | 20s. METHOD OF DISPOSIT | PLACE OF DISPO | 23 Edmondson Ave. Catonsville, Md.21228 | | | | | | | | | | | |
| | 1 Buriel 2 Crematic | on 3 🗆 Rem | noval from State | 1 - | other place) reenmo | | | • | | | | | • | |
| | 21. SIGNATURE OF FUNERA | _ | CENSEE | | | Dunt Crematory Baltimore, Md. 22. NAME AND ADDRESS OF FACILITY Sterling Ashton Funeral Home, Inc. | | | | | | | | |
| è | D | | 1.6) | 0- | | S | te: | rlin | g As | shton | Fun | eral | . Hon | ne, Inc. |
| - 1 | 23. PART i. Enter tha d | | - 12V | 40 | LABORATE AT TO | | | | | | | | | 11e Md. |
| | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Arteriosclerotic Cardiovascular Disease Due To (or as a consequence or): | | | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| ATION | Sequentially list conditions, If any, leading to immediate | | | | | | | | | | | | | |
| ERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c | | | | | | | | | | | | | |
| O | PART II. Other significa | ant conditio | ns contributing t | o death b | ut not resulting | in the ur | derivi | ng cause | given in | Part i. 24 | . WAS AN | AUTOPSY | 24b. W | VERE AUTOPSY FINDINGS |
| MEDICAL | | | | | | ig in the underlying cause given in Part | | | | PERFOR | | A | MAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | | | | | | | _ ' | YES 2 | KIXNO | | F DEATH? | |
| - | - | | | | | | | | | _ 1 | nspe | ection | | 20 2 NO |
| SICIAN: | 25. WAS CASE REFERRED T | TO MEDICAL | | | | | 26. | PLACE OF I | DEATH (Ch | eck only one) | | | | |
| SIC | EXAMINER? | | HOSPITAL: | ☐ ER/Outp | entient 3 DOA | OTHE1 | | me 5 M R | esidence | 6 Other (Sp | pecify) | | | |
| РНУ | 27. MANNER OF DEATH | | 28e. DATE C | Day, Year) | 28b. TI | | 28c. II | NJURY AT | | 28d. DESCR | _ | NJURY OCC | CURED | = *** - |
| ВУР | 1 Netural 5 2 Accident | Pending Investigation | (Incents, | _ ay, /om/ | " | M | | YES 2 | ON [| | | | | |
| ETED 8 | 0 🗆 0.4-14- | Could not be determined | 28e. PLACE building | OF INJURY 9, etc. (Spec | — At home, ferm | street, fac | tory, of | lice | | 28f. LOCATIO City or R | ON (Street own, State) | and Number | or Rural Ros | ute Number, |
| COMPLE | CONSTRUCTION OF THE PARTY OF TH | | SICIAN: To the best | | | | | | | | | | | and manner ee stated. |
| | | E OF CERTIFIE | | | | | | | ENSE NU | | , | , | | Month, Day, Year) |
| TO BE | M | 1 | X | > | | | | 250. 00 | OCM. | | | DATE DATE | 12-8 | |
| _ | Ann M. | Dixon. | M.D. | | 111 | | St | ., Ba | lto. | , Md. | 212 | 201 | | |
| | 31. DATE FILED (Month, Day, | 1000 | 32. REGISTI | RAR'S SIGN | Handase | | | | | | | | | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



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| NDING PHYSICIAN: The law requires that t | R: After this certificate has been signed by a death with the State Dent of Health an | is marked, or item 23 shows an |
| ATTENDING PHYSICIAN: The law requires that t | CTOR; After this certificate has been signed by | 28 is marked, or item 23 shows an |
| OR ATTENDING PHYSICIAN: The law requires that t | DIRECTOR: After this certificate has been signed by | tem 28 is marked, or Item 23 shows an |
| TAL OR ATTENDING PHYSICIAN: The law requires that t | 3AL DIRECTOR: After this certificate has been signed by | If Item 28 is marked, or Item 23 shows an |
| SSPITAL OR ATTENDING PHYSICIAN: The law requires that t | JNERAL DIRECTOR: After this certificate has been signed by | INT. If Item 28 is marked, or Item 23 shows an |
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| TO THE HOSPITAL OR ATTENDING PRYSICIAN: The law requires that the death certificate be executed within 27 mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and with the State hard of the Health and Mental Haviere prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG. NO. | 0 34202 | | | | | | | | |
|-----------------------|---|---|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) I RUING SIMOS 2. OATE OF OEATH DAY 9 YEAR 90 | 3. TIME OF DEATH 621 Pm | | | | | | | | |
| | 475-16-7047 1 PM 2 F 68 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 22 MI | | | | | | | | | |
| TOR | 90. FACILITY NAME (If not institution, give street and number) Secretary NAME (If not institution, give street and number) Secretary NAME (If not institution, give street and number) BESIDENCE OF DECEMENT Secretary NAME (If not institution, give street and number) BESIDENCE OF DECEMENT | , | | | | | | | | |
| DIRECTOR | | 10d. INSIDE CITY LIMITS? 1 AES 2 NO | | | | | | | | |
| FUNERAL | 100. STREET AND NUMBER 100. CTIZEN OF 20814 US | WHAT COUNTRY? | | | | | | | | |
| B | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 No Specify: Spe | CE — American Indian, ck, White, etc. city: White | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5+) Research Administration NIH | | | | | | | | | |
| | | | | | | | | | | |
| TO BE | 10. INFORMANT'S NAME (Top-Origin) | | | | | | | | | |
| | 20a. METHOO OF DISPOSITION 1 Gurlet 2 Germetton 3 Removal from State 4 Donellon 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of complexy, cremetory or Alexandria, Va. | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE MCENSEE 22. NAME AND ADDRESS OF FACILITY I ves-Pearson Funeral Home Falls Church, Va. 22046 | 9 S | | | | | | | | |
| | 23. PART L'Errer the disease, or complicatione that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finei disease or condition resulting in death) a. AMY OTROPHIC LATERAL SCLEROSIS | Approximate interval Between Onset and Death | | | | | | | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentlelly list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | | | | | | | | |
| PHYSICIAN: MEDICAL CE | PART ii. Other aignificant conditiona contributing to deeth but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY PERFORMED? | PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Input tent 2 EN/Output tent 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | |
| ву РНУ | | | | | | | | | | |
| | | al Route Number, | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner as stated. | e(e) and manner ea stated. | | | | | | | | |
| то ве с | 296. SIGNATURE AND TITLE OF CERTIFIER 296. DEC DEC DE DEC DE CERTIFIER 296. DEC DEC DE DEC DE DEC DE DE DE DE DE DE DE DE DE DE DE DE DE | ED (Month, Day, Year) 10, 1990 | | | | | | | | |

8830 CAMERON ST.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

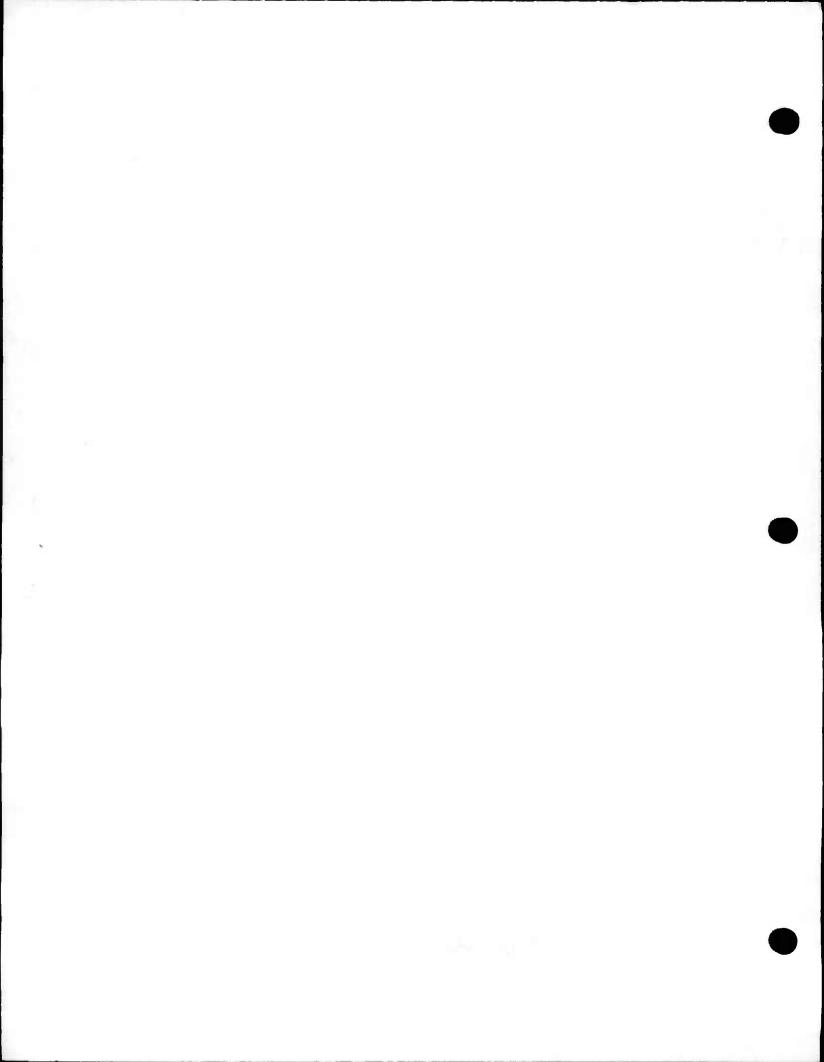
EDWARD

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SPRING MA

SILVER



| ecuted within 2 mours after death. Page 6 may be retained by the hos | nd completely filled in by the funeral director, page 5 should be detach burial, cremation, or removal. | itic event, the medical examiner must be notified at once. | ON TO BE COME |
|--|---|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a frous after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache he find within 72 hours after death with the State Dest. of Health and Mental Hodiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| _ | REGISTRAR CERT | TIFICATE OF D | DEATH | REG. NO. | | | | | | |
|-----------------|--|--|--|-------------------------|---------------------|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Mattie. B., Testermo | 20 | 2. | DATE OF DEATH | YEAR O | 3. TIME OF DEATH 200 OM | | | | |
| | 4. SOCIAL SECURITY NUMBER 8. SEX 8. AGE (in yrs. lest birth | | | DATE OF BIRTH | 8. BIRTI | HPLACE (State or Foreign | | | | |
| | 001301081 - 1 | RS. MONTHS DAYS H | - T | Month, Day, Year) | 74 Ro | N) III | | | | |
| _ | Sa. FACILITY NAME (If not institution, give street and number) | 96. CITY, TOWN OR | LOCATION OF DEATH | , | 9c. COUNTY OF E | | | | | |
| ξ | RESIDENCE OF DECEDENT | FALLS | 101 | | HARF | ORO | | | | |
| į | | c. CITY, TOWN OR LOCATION | N | | | 10d. INSIDE CITY LIMITS? | | | | |
| 5 | MARYLAND HARFORD | FALLSTO | | | | 1 ☐ YES 2 NO | | | | |
| UNERAL DIRECTOR | 104. STREET AND NUMBER | 101. Z | P CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECEN | DENT OF HISPANIC O | RIGIN? (Specify Yes | or No.— 14. BAC | E American Indian, | | | | |
| | 1 Never Merried 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, spect | fy Cuben, Mexican, Pu | ierto Rican, etc.) | Biac Spec | k, White, etc. | | | | |
| | - Contained - Or Contained | ENT'S USUAL OCCUPATION | | | -1ω | अगर | | | | |
| | (Specify only highest grade completed) (Give kin | nd of work done during most of VOT use retired.) | of working | 16b. KIND OF BUS | INESS/INOUSTRY | | | | | |
| 3 J | 6 YRS. A | I HOME | | | | | | | | |
| O M | 17. FATHER'S NAME (First, Middle, Last) | | 6. MOTHER'S NAME (| First, Middle, Melden S | Sumame) | | | | | |
| | JULIA GLASS | | LICE | LA ST | 300 | | | | | |
| 2 | 198. INFORMANT'S NAME (Type/Print) FAMILY RECORDS | LILING ADDRESS (Street and | 0 - | | , State, Zip Code) | | | | | |
| | 20s, METHOD OF DISPOSITION 20b, PLACE OF DI | ISPOSITION (Name of comet | ABOU ery, crematory or | | ATION City or To | own, State | | | | |
| | 1 Burlei 2 Cremation 3 Removal from State 4 Donation 6 Other (Specify) | IAINVIEW | Csm. | Ru | RAL RE | REAT VA. | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAME AND | ADDRESS OF FACILITY | "= Mir | ORIES | | | | | |
| | Loralla to ENano, /h | 8300 | HARFOR | R080- | PARKUI | 2.6 | | | | |
| | 23. PART i. Enter the diseases, or complications that caused the deeth. shock, or heart failure. List only one cause on each line. | Do not enter the mode | of dying, such as | cardiac or reapi | atory errest, | Approximate Interval Between | | | | |
| | IMMEDIATE CAUSE (Fine) disease or condition ACOLO O | 10,000 0 11. | an | 1 | | Onset and Death | | | | |
| | resulting in death) a | CUVUD CCC |) Um | 101 | | MINUAS | | | | |
| | - MASONE | CVA | , | | | doup | | | | |
| 101100 | Sequentially list conditions, if eny, leading to immediate | | | | | | | | | |
| | Cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENT) | TSC | VI | | | VCOZ | | | | |
| | that initiated events resulting in death) LAST | | | | | / | | | | |
| 5 | PART II. Other aignificent conditions contributing to death but not result | almos to the sendent to a | and the Board | . [.] | | | | | | |
| \$ | FANT II. Other argumeent continues contributing to death but not result | ting in the underlying o | euse given in Pan | PERFOR | MED? | b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| 2 | | | | 1 TYES 2 | □ NO | OF DEATH? | | | | |
| | | | | | | . LIES Z LINU | | | | |
| SICIAIN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 26. PLAC | CE OF DEATH (Check of | only one) | | | | | | |
| E L | 1 YES 2 NO 1 Nonpatient 2 ER/Outpatient 3 D | OA 4 Nursing Home | 5 🗆 Residence 8 🗆 | | | | | | | |
| | Natural 5 Pending (Month, Day, Year) | b. TIME OF 28c. INJURY WORK | 7 AT 254 | d. DEŞCRIBE HOW IN | JURY OCCUREO | | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be building, etc. (Specify) | | The state of the s | . LOCATION (Street a | nd Number or Rural | Route Number, | | | | |
| 2 | 4 Homicide determined building, etc. (Specify) | | | City or Town, State) | | | | | | |
| | 29a. CERTIFIER (Check only (Ch | occurred at the time, date er | nd place, and due to t | he cause(a) and man | ner as stated. | | | | | |
| - 1 | | | th necessari at the time | , date and place, and | t due to the causel | No. of the last of | | | | |
|) | one) 2 MEDICAL EXAMINER: On the basis of examination and/or invest | digation, in my opinion, dea | til occorde at the time | | doe to the cause(| a) and manner as stated. | | | | |
| NE COM | one) | 1 2 | PC LICENSE NUMBER | | 29d. DATE SIGNE | | | | | |
| 3 | 2 MEDICAL EXAMINER: On the basis of examination and/or invest 29b. SIGNATURE AND TITLE OF CERTIFIER | MO ! | Hard Control of the Control | | HACE SELECTION | | | | | |
| 20 20 | one) 2 MEDICAL EXAMINER: On the basis of examination and/or invest | MO ! | Hard Control of the Control | | HACE SELECTION | | | | | |
| DE CO | 2 MEDICAL EXAMINER: On the basis of examination and/or invest 29b. SIGNATURE AND TITLE OF CERTIFIER | MO ! | Hard Control of the Control | | HACE SELECTION | | | | | |
| 20 20 | 29b. SIGNATURE AND TITLE OF CERTIFIER 36. NAME AND ADDRESS OR PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) 200.3 KOCK SPRING ROLL ROLL ROLL ROLL ROLL ROLL ROLL ROL | (Type, Print) FORE | Hard Control of the Control | | HACE SELECTION | | | | | |

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|---------------------|-------------------------------|
| MARYLAND 21203-3146 | nepital or attending |
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| LTIMORE, | Dane |
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TO BE COMPLETED BY FUNERAL DIRECTOR

OF VITAL RECORDS, P.O. BOX 13146,

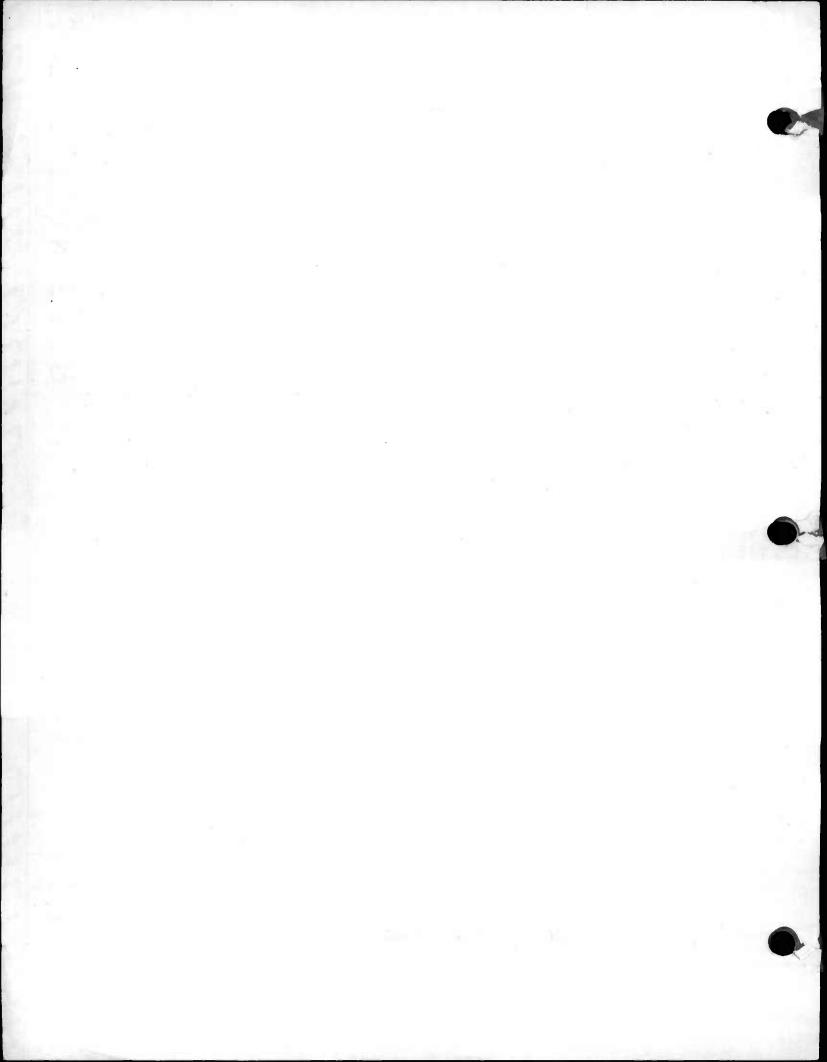
| | YSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | s certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | cremation, or removal. | ted, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---------------------------------------|--|---|---|--|
| CALCALOT VIEW DECONDS, F.O. DON 1915, | DEPTIAL OF STEELS HYSICIAN. The law requires that the death certificate be execute | METAL SUFFERENCE IN SCALIFICATE has been signed by the attending physician and co | me 72 hours men count with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | ART: If them 28 is marked, or item 23 shows any injury, or other traumatic |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | | STATE OF I | MARYLAND / DEPA CERTII | | | | | | YGIENE EG. NO. | 90 | 3 |
|---------------------------|---------------------|-------------------|-------------------------------|---------|----------|-----------|---------|--------------|-------------------|-----------|-------|
| 1. DECEDENT'S NAME (FI | rst, Middle, Last) | Tille | ery | | | | | 2. DATE OF D | DAY | 9U | 3. T |
| 4. SOCIAL SECURITY NUI | MBER | 5. SEX | 8/AGE (In yrs. lest birthday, | IF UNDE | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF B | | 8. BIRT | |
| 217-07-4 | 267 | 1 🗆 M 2 💢 F | 80 YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day | 3-7 // | Cour | ntry) |
| 9a. FACILITY NAME (# not | inatitution, give a | treet and number) | 0 1 | 9b. CIT | Y, TOWN | OR LOCATI | ON OF D | EATH | 9c. | COUNTY OF | DEATH |

| 1. DECEDENT'S NAME (First, Middle, Least) | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF DEATH |
|---|---|--|
| 4. SOCIAL SECURITY NUMBER 5. SEX 8 AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UND 2 17 - 17 42 57 1 M 2 XF 80 YRS. MONTHS DAYS HOURS | DER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCA | 110N OF DEATH 9c. COL | INTY OF DEATH |
| RESIDENCE OF DECEDENT | | |
| 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION Ba / A | | 10d. INSIDE CITY LIMITS? 1 YES 2 \(\square\) NO |
| 3323 Hondannia 2 | 10g. CIT | 1 - S.A |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify you 1 YES, GIVE WAR OR DATES 13. WAS DECENDENT If yes, specify you 1 YES, GIVE WAR OR DATES | T OF HISPANIC ORIGIN? (Specify Yes or No—ban, Maxican, Puerto Rican, stc.) O Specify: | 14. RACE — American Indian, Black, White, atc. Specify: Black |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. DECEDENT'S USUAL OCCUPATION (Give work done during most of work life. Do NOT use retired.) | 16b. KIND OF BUSINESS/IN | DUSTRY |
| | OTHER'S NAME (First, Middle, Melden Surname) | |
| 199. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Num) 191. MAILING ADDRESS (Street and Num) 9812 Retrigg. | ber or Rural Route Number, City or Town, State, Z | (code) 21/33 |
| 20s. METHOD OF DISPOSITION 1 | Port Or De La Contraction - | City or Town, State |
| 21. SECHATURE OF FUHERAL SERVICE LICENSEE 22, NAME AND ADDI | RESS OF FACILITY F. H. West | A |
| 23. PART I. Enter the diseases or complications that caused the death. Do not anter the mode of a shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | Interval Between Onset and Death |
| PART II. Other algoriticent conditions contributing to death but not resulting in the underlying cause | e given in Part I. 24a. WAS AN AUTOPS' PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 TWO |
| | F DEATH (Check only one) | 7 |
| | Rasidence 6 Other (Specify) | |
| 27. MANNER OF OEATH 1 Autural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 1 YES 2 | | CCURED |
| 3 Suicide 6 Could not be 4 Homicide 6 Could not be detarmined 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, atc. (Specify) | 26f. LOCATION (Street and Numb City or Yown, State) | er or Rural Route Number, |
| 29s. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and plate one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, das | | |
| Ilrana L. Jak Med. ICU Physicia 1 | 29d. DA | TE SIGNED (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) TERANCE L. AMB LIBERTY MEDICAC | CENTER Baltimo | re , Md 212 15 |
| 31. DATE FILED (Month, Day, Yold) DEC 1 3 1990 32. REGISTRAR'S SIGNATURE And Sunday - Randall | | |

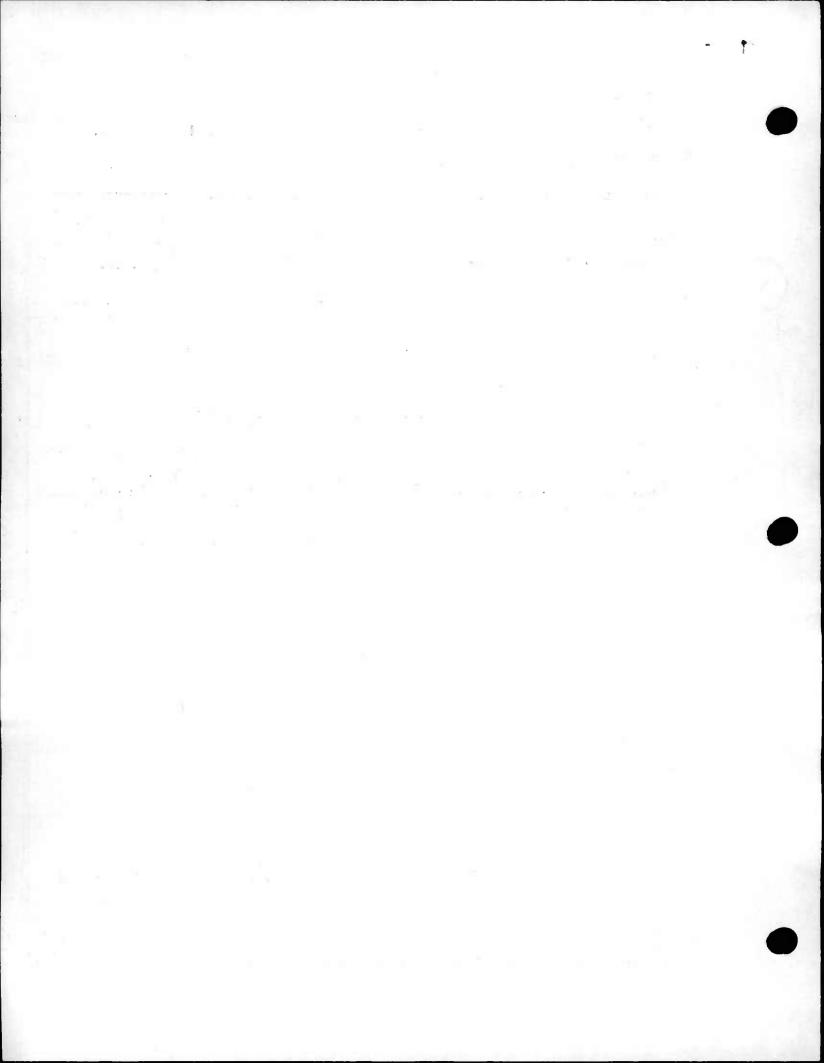
DHMH-16 Rev 1/89



rmit. Pages 1, 2, 3 should

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|---|------------|--|
| age | | pe |
| rector, p | | must |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 s | | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be not |
| in by the | or removal | nedical |
| filled | On, (| he r |
| ompletely | , cremati | event, t |
| in and co | to buria | umatic |
| ysicia | prior | tra |
| ding ph | lygiene | othe |
| Item | <u>50</u> | 9 |
| the at | Ment | Injury |
| 5 | an | liy. |
| signe | Health | E SMC |
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| has b | Dept | 23 |
| ficate | State | Herr |
| Serti | the | 0 |
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| After | death | S ma |
| .TOR: | after | 28 |
| DIREC | hours | Item |
| ZA. | 2 | = |
| FUNEF | within | TANT |
| THE | be filed | MPOR |
| | | |

| | 1 - STATE REGISTRAR | STATE OF MAR | | | F HEALTH A | | NTAL HYGIENE REG. NO. | | |
|----------------------|--|---|------------------------------------|-----------------|---|-------------|---|---------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | elen E. Wa | igner | | | DATE OF DEATH DAY | 990 YEA | 3. TIME OF DEATN 5:40 M |
| ~ | 4. SOCIAL SECURITY AND APPERS 187-05-6739 90. FACILITY NAME (If not institution, give s | 1 🗆 M 2 📈 F | SE (In yrs. lest birthdey) 84 YRS. | | WN OR LOCATION | MIN. | DATE OF BIRTH (Month, Day, Year) 10/22/06 | Co | RTNPLACE (State or Foreign unity) NNSYLVANIA F DEATN |
| DIRECTOR | The Wesley RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | | | Y, TOWN OR L | Baltin | nore | , Md. | | |
| L DIRE | Md. | | 10c. CI | Y, IOWN OR L | Baltin | nore | | 40-1017175114 | I I YES 2 NO |
| FUNERAL | 2211 W. Ro | | | | 2 | 1209 | | U. | S.A. |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT, EVE FORCES? 1 Y IF YES, GIVE WAR OF | | If ye | DECENDENT OF s, specify Cuban, YES 2 NO | Maxican, Pu | RIGIN? (Specify Yes o serto Ricen, etc.) | B | ACE — American Indien, Black, While, atc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12) 1.2 | CATION completed) College (1-4 or 5+) | Ilfe. Do NOT L | work done durin | ng most of working | | | omemake | |
| BE CO | | lavel Seitz | | | | Ella | - | | |
| 5 | Jacqueline Sturg | ges | P.O. | Box 17 | 71725 B | Bethes | sda, Mary | State, Zip Code Land 2 | 0817 |
| | 20a. METHOD OF DISPOSITION 1 | oval from State | 20b. PLACE OF DISPO | | of cometery, cremet cematory | , | | ation — city o onsvill | Le, Maryland |
| | 21. SIGNATURE OF PINERAL SERVICE LI | LL Can | senter | 7 | AE AND ADDRESS | Burge | ee-Henss l | Funeral | Home aryland 21211 |
| CERTIFICATION | 23. PART I. Enter the diseases shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. Cluma DUE TO (OR A DUE TO (OR A | n each line. | D(54 | | | | | Approximate Interval Between Onset end Death |
| PHYSICIAN: MEDICAL C | PART II. Other significant condition | s contributing to deat | h but not reaulting | in the unde | rlying cause giv | ven in Pari | 24e. WAS AN A PERFORM | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 1 YES 2 JANO |
| ICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 8. PLACE OF DEA | | | | |
| B∀ | 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 1 Inpettent 2 ER/Outpettent 3 DOA 4 Aursing Nome 5 Residence 8 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28d. DESCRIBE HOW INJURY OCCURED | | | | | | | |
| ETED. | 4 Homicide determined | building, atc. (| Specify) | | | | City or Town, State) | | |
| COMPLET | (Check only | ICIAN: To the bast of my ki | | | | | | | se(s) and manner as stated. |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIE | + Jebert | 5, no. | | 29c. LICEN | SE NUMBER | V. | | NED (Month, Day, Year) 2-12-90 |
| F | 30. NAME AND ADDRESS OF PERSON WA | | | s, Print) | | | | | |
| | DEC 13 1994 | full deviden | information. | | | | | | |



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should non, or removal. urs after death. Page 6 may be retained by the hospital or attending physician. notified at must be examiner traumatic event, the medical Hygiene prior to burial, cremation, has been signed by the attending physician and completely . Dept. of Health and Mental Hygiene prior to burial, cremati requires that the death certificate be executed within injury, or other shows any ALTENDING PHYSICIAN: The law 23 item this certificate h 5 the marked, After t

FOR STATE REGISTRAR

4. SOCIAL SECURITY NUMBER

Lincoln

10e. STREET AND NUMBER

11. MARITAL STATUS

1 Never Married

NA

ertrude

IMMEDIATE CAUSE (Final

CAUSE (Diseese or Injury

thet initisted events regulting in deeth) LAST

disease or condition

reculting in death)

10a STATE

1 -

DIRECTOR

FUNERAL

BY

ETED 1

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BE (

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CERTIFICATION

PHYSICIAN: MEDICAL

BY

O'BE COMPLETED

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RECTOR.

34206 90 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF CEATH PAY Step 1997 ard 12 5. SEX 8. AGE (In yrs. last birthdev) 7. DATE OF BIRTH IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 3 HOURS DAYS 1 X M 2 - F 9c. COUNTY OF OEATH 9b. CITY. TOWN OR LOCATION OF DEATH Vensm 1217 RESIDENCE OF DECEDENT 10b. COUNTY INC. CITY TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 | NO 10g. CITIZEN OF WHAT COUNTRY? 101, ZIP CODE W. Lan 5 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify # yes, specify Cuban, Maxican, Puarto Rican, atc.)

1 Yes 2 No Specify: 2 Married Black 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high Collega (1-4 or 5+) Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) 19a INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street 5 7 Ho, MU owar 21229 20a METHOD OF DISPOSITION
1 Surfal 2 Cremation 3 Ram
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Na 2100 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Grome 1ar 23. PART |. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, such se cerdisc or respiretory strest, Approximate hock, or heart fallure. Liet only one ceuse on Interval Between Onset end Deeth Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING DUE TO (OR

| | M M I | | | | | |
|--|--|------------|--------------------|---------------------------------|---|--|
| PART II. Other significent condition | ns contributing to death but not in the second seco | resulting | λ | nderlying ceuse given in P | art I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| 5. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHE | | | |
| 1 TYES 2 NO | 1 - Inpetient 2 DER/Outpetient 3 | DOA | 4 🗆 Nu | rsing Home 5 🗆 Rasidenca 8 | ☐ Other (Specify) | |
| 7. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | IE OF JURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCU | PRED |
| 3 Suicide 8 Could not be | 28s. PLACE OF INJURY — At he building, stc. (Specify) | ome, farm, | street, fac | ctory, office | 281. LOCATION (Street and Number of City or Town, State) | Rural Route Number, |

1 DCERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and placa, and due to the cause(a) and manner as atsted.

2 MEDICAL EXAMINER: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated.

| b. SIGNATURE AND TITLE OF CERTIFIER | Jan mo | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|-------------------------------------|--------|---------------------|-------------------------------------|

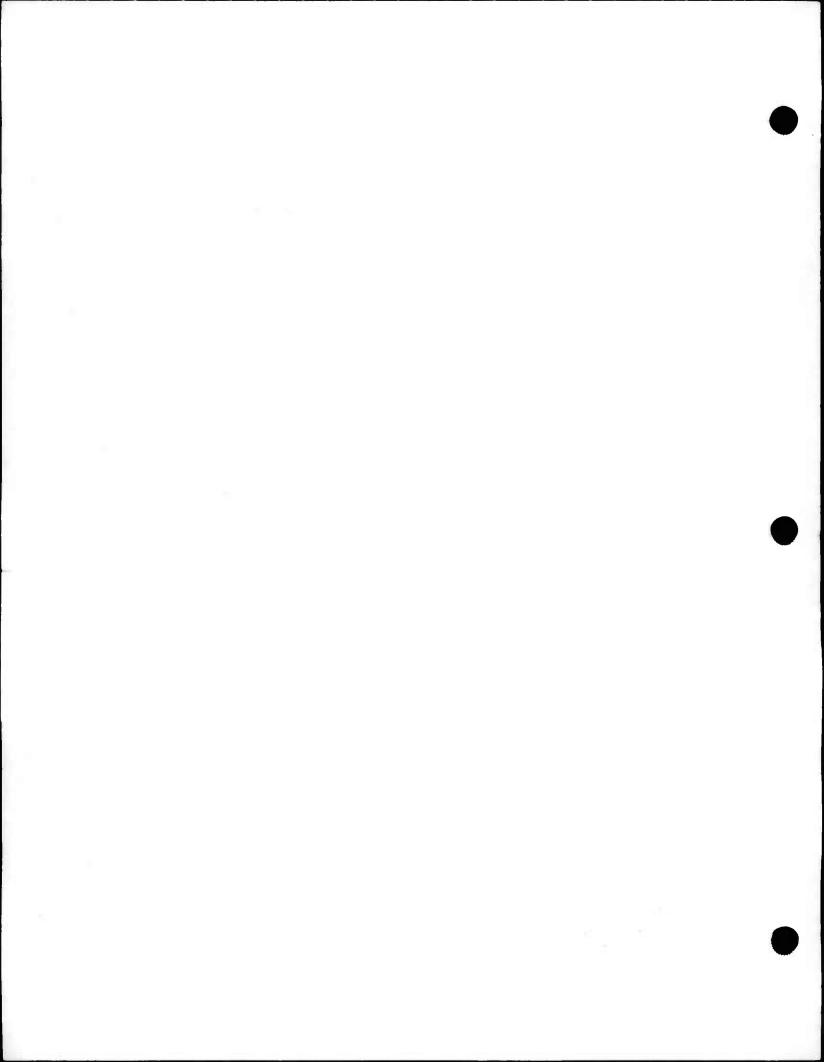
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21222



| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | BALLIMORE, MARYLAND 21203-3146 |
|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician. | be retained by the hospital or attending physician, |
| TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buriat-transit i | ge 5 should be detached for use as the burial-transit |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | |
| IMPORTANT If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | ie notified at once. |

| | 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. |
|----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) NEBER 2. DATE OF DEATH NONLY YEAR M M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lapt birthday) 1 |
| TOR | 98. FACILITY NAME (If not institution, give street and number) 99. CITY, TOWN OR LOCATION OF DEATH TARROTTSVILLE HARRORD CO. |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 UPS 2 100 |
| FUNERAL | 100. STREET AND NUMBER 2500 GREEN SPRING CT. 101. ZIP CODE 210.85 109. CITIZEN OF WHAT COUNTRY? U.S. A. |
| BY FUN | 11. MARITAL STATUS 1 |
| LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5 +) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AMURICAN RAWL STATIONARY |
| BE COMPLET | 17. FATHER'S NAME (First, Middle, Lest) WILLIAM MYRRAY 16. MOTHER'S NAME (First, Middle, Melden Sumerne) MARCARET RANDALL |
| TO B | 19a. INFORMANT'S NAME (TyperPrint) FAMILY FECORDS 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE |
| | 20s. MPTHOD OF DISPOSITION 1 Partial 2 Cremetion 3 Removal from State 4 Donation 5 Dither (Specify) 20b. PLACE OF DISPOSITION (Name of complex), cremetory or PARKULLE MD 20c. LOCATION — City or Town, State PARKULLE MD **PROVIDED MD **PROVID |
| | 21. SIONATURE OF FUNCIONAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY EVANS FUNCIONAL CHAPEL 24. NAME AND ADDRESS OF FACILITY EVANS FUNCIONAL CHAPEL |
| | 23. PART I Enter the diseases of complicatione that caused the death. Do not enter the mode of dying, such as cerdiec or reepiratory arreat, above, or near failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition reculting in death) Due To (or As A consequence of): |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c. |
| ERTIF | that initiated events reaulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): |
| PHYSICIAN: MEDICAL C | PART II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALIBLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO |
| TED BY PHYSICIAN | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF VORK? 1 Netural 5 Pending M 1 YES 2 NO |
| TED BY | 2 Accident investigation 3 Suicide 8 Could not be building, atc. (Specify) 28a. PLACE OF INJURY — At home, ferm, atreet, factory, office City or Town, State) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) |
| D BE COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and place, and dua to the cause(a) and menner as stated. |
| TO BE (| 296. SIONATURE AND TITLE OF CERTIFIER 290. LICENSE NUMBER 290. LICENSE NUMBER 290. DATE SIGNED (Month, Day, 1964) 12-10-1990 30, NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) |
| | DR. TYSON 11706 SILVER SPRUCE TARRACE KINGSVILL 31. DATE FILED (MONTH). DAY VONT) 12. REGISTRAP'S SIGNATURE |
| | DEC 13 1990 July Fundson Bindales |

DHMH-16 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE AND ALTENDING PHYSICIAN: The law requires that the death certificate be executed within 23-mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FLOOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, 2, 3 should be filled in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

MEDORITANE II Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. 日本田田

| | FOR STATE REGISTRAR | STATE OF MARYLAND | DEPARTMENT ERTIFICAT | | | MENTAL | HYGIENI REG. NO. | E | | |
|-----------------|--|--|--|----------------------|---|--------------|------------------------------------|-------------------|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) MILTON J. ZIE | linski | ton J. Z | | | 2, DATE (| 2 9 | | O | 1205 pm |
| | 220-05-3894 | 5. SEX 6. AGE (In yrs. Is 1 ☑ M 2 ☐ F 69 | YRS. MONTH | 25,10 | IF UNDER 24 HRS. HOURS MIN. | July | Day, Year) 4 192 | 21 1 | Maryl | e (State or Foreign and |
| TOR | 9a. FACILITY NAME (If not institution, give stre Harford Memorial RESIDENCE OF DECEDENT | | | | De Grace | | | 9c. COUNTY Har | ford | |
| DIRECTOR | 10a. STATE 10b. COUNTY | ford | Abin | N OR LOCAT | ION | | | - | | INSIDE CITY LIMITS? |
| ERAL | 10a. STREET AND NUMBER 3913 E. Baker A | venue | | 101. | ZIP CODE | 1009 | | Unite | of WHAT | |
| BY FUNERAL | 11. MARITAL STATUS 1 Naver Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 📉 YES 2 🗆 IF YES, GIVE WAR OR DATES WWW. I | RMED 1 | | ENDENT OF HISPAN celly Cuban, Maxico 2 X NO Specify | n, Puarlo R | | or No- 14 | Black, Wh Specify: | merican Indian, Ita, atc. White |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elamantary/Secondary (0-12) | College (1-4 or 5+) | Give kind of work do. B. Do NOT use retired | ne during mo: d.) | st of working | 16b. | KIND OF BUS | SINESS/INDUS | TRY | |
| NO. | 17. FATHER'S NAME (First, Middle, Last) | 1_31 | reer Mero | II WUI | 16. MOTHER'S NA | ME (First, M | liddle, Maiden | Surname) | | |
| BE | Walter | 7ielinski | | | Rose | | | Lewic | | |
| ဥ | 19a. INFORMANT'S NAME (Type/Print) | | | | Ave. A | | | | | |
| | 20a. METHOD OF DISPOSITION 1 X Burlat 2 Cremation 3 Improve | 20b. PLACI | of disposition Stanisla | (Name of cen | netery cremetory or | 2/90 | 20c. LO | cation — cit | | ryland |
| | 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAY SERVICE LICE | NSEE | | | D ADDRESS OF FA | | | | Ma | ryranu |
| | Ernest F | T III | | | ird J. Ru | | Inc. | | | rd Road |
| | 23. PART I. Entar tha disasses, or co shock, or heart failure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | ARRHYT | MIA | | | | | | , | Approximata Interval Batwean Onsat and Death |
| CERTIFICATION | Sequentisity list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST | POE 10 (OIL NO N CONS | OSCU | | 81S |)(5(| A d C | | | |
| CAL | PART II. Other significant conditions | contributing to death but not | resulting in tha | undariying | g cause given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | MED? | AVAI CON OF | E AUTOPSY FINDINGS LABLE PRIOR TO IPLETION OF CAUSE DEATH? YES 2 NO |
| ä | | | | | | | | | | |
| PHYSICIAN: MEDI | | HOSPITAL: | 3 DOA 4 | IER: | ACE OF DEATH (Ch | | | | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | | URY AT IRK? YES 2 NO | 28d. DES | CRIBE HOW I | NJURY OCCU | RED | |
| TED BY | 3 Suicide 6 Could not be datarmined | 28e. PLACE OF INJURY — At I building, atc. (Specify) | nome, farm, atreet, | factory, offic | | | ATION (Street a or Town, State) | and Number or | Rural Route | Number, |
| COMPLETED | one) | IAN: To the best of my knowledge, on the basis of examination and/o | | | | | | | | I manner as stated. |
| H | GONATURE AND TITLE OF CERTIFIER | enabel, mp | | | 29c. LICENSE NUI | MBER | | 29d. DATE S | 2/8 | nth, Day, Year) |
| ٩ | PANTE U | COMPLETED CAUSE OF DEATH (IT | EM 27) (Type, Print) | ovre | de Gra | re | Md | 21 | 078 | , |
| | 31, DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | | | | | |

Maryland Harford

3913 E. Baker Avenue

and the second of the second of the second of

Abington

Beatrice Zielinski 3913 E. Baker Ave. Abingdon, Md. 21009

St. Stanislaus Cem. Baltimore Maryland

Leonard J. Ruck, Inc. 5305 Harford Road

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White

21009 . United States

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examiner must funeral director,

page 5 should notified

filled in by the floring or removal.

Pages 1, 2, 3 should

permit.

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34209 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9 YEAR iRg, NIA 5 12 7. DATE OF BIRTH (Month, Day, Year BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In vrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. DAY 1 M 2 X F 74 215-10-8367 2-10-1916 Michigan 9c. COUNTY OF OEATH 9e. FACILITY NAME (If not Institut 9b. CITY, TOWN OR LOCATION OF DEATH OSK ACTIMORE OWSON DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 1 YES 2 NO Baltimore Baltimore Maryland FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 21239 U.S.A. 5305 Loch Raven Blvd. 11, MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES If yes, epecify Cuben, Mexicen, Pt 1 YES 2XX NO Specify: 1 Never Merried 2 Merried Specify: White BY 3 XWidowed 4 Divorced ETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 5+) COMPL 4th Grade Housewife 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surneme) Antoinette Lombardo Vincent Albione BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 2507 Port Lane Fallston, MD 21047 Mr. Vincent M. Agro 20a. METHOO OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State 1 Donation 5 Other (Specify) 6/en Burnit, Maryland Holy Cross Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. My. 8728 Liberty Road Randallstown, MD 21133 23: PART I. Enter the diseases, Dr complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximats Interval Between Onset and Desth IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease Dr Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST 010 PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24e. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Oulpatient 3 | DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28c, INJURY AT WORK? 28e. DATE OF INJURY 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO BY 2 Accident Investigat 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 8 Could not be 4 Homicide 29e CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, data end piece, end due to the ceuse(e) end menner es stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and menner so stated 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE my 0

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31. DATE FILED (Month, Day, Year)

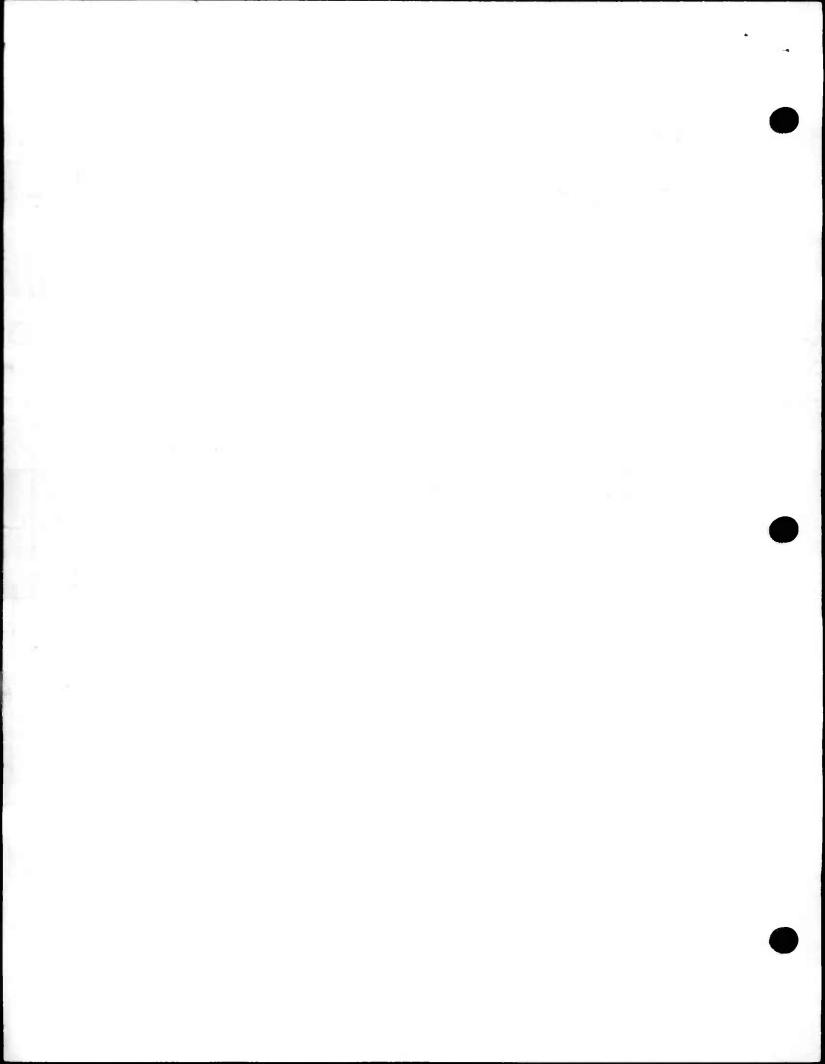
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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Davidson Randall



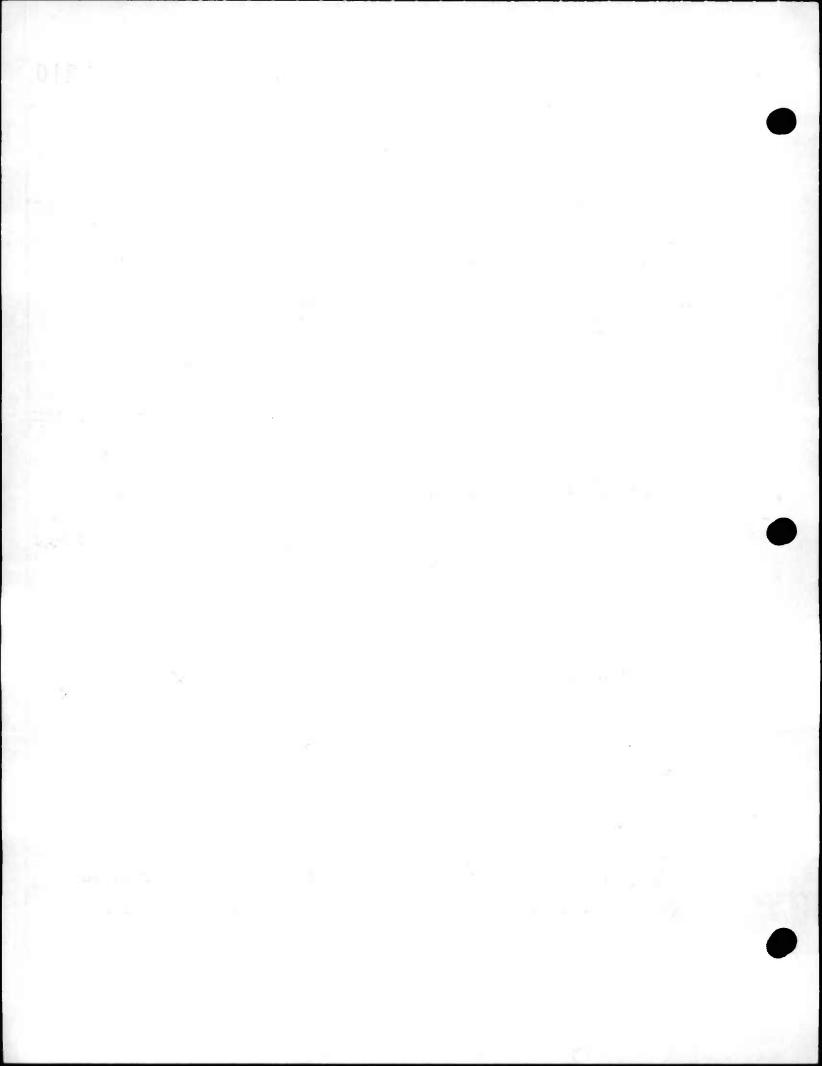
be detached for use as the burial-transit permit, Pages 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x nours after death, Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL CURECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-trans | be filed within 72 hours after death with the State Dept, of Health and Merital Hytliene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|--|
| equires that the death | an signed by the atten | of Health and Merital P | hows any injury, o |
| HYSICIAN: The law re | is certificate has been | with the State Dept. of | ed, or Item 23 s |
| DR ATTENDING P | DIRECTOR: After the | yours after death y | tem 28 is mark |
| TO THE HOSPITAL | TO THE FUNERAL | be filed within 727 | IMPORTANT: If I |

| | FOR STATE OF MARYLAND A | DEPART | | | | | MENTAL | HYGIENE REG. NO. | |) 0 | 0 7 6 1 0 |
|-----------------|--|------------------------|-----------------|------------|----------------------------|-------------|--------------|----------------------------------|-----------|-------------------------|--|
| ! | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. OATE (| DAY | | YEAR | 3. TIME OF OEATH |
| | HELEN M. ARRINGTON 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. Io. | st birthday) | IF UNDER 1 | YEAR | IF UNDER | 24 HRS. | 1.2 | 14 F BIRTH | | 8. BIRTI | 4:00 A. M |
| | 212-10- 7375D 1□M2⊠F 76 | | IONTHS | DAYS | HOURS | MIN. | (Month, | 29 1 | .4 | Count | (ARYLAND |
| E I | B. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DE 3640 BUENA VISTA AVENUE BALTIMORE | | | | | | ATH | | 9c. COU | NTY OF C | DEATH |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10c. CITY. | TOWN OF | 2 LOCAT | ION | | | | | | 10d. INSIDE CITY |
| DIRECTOR | MARYLAND | 100.011, | BALT | | | | | | | | LIMITS? |
| | 10a. STREET AND NUMBER | | Ditto. | _ | ZIP CODI | | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| FUNERAL | 3640 BUENA VISTA AVENUE | | | | 21 | 211 | | | | US | SA |
| BY FUR | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Olvorced 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 THE FORCES? 1 YES 2 THE FORCES? 1 YES, GIVE WAR OR DATES AND THE FORCE OF THE FORC | RMED NO | 16 | yes, sp | ENDENT Color | n, Mexica | n, Puarto R | (Specify Yes lcan, atc.) | or No | 14. RAC Blac Spec | E — American Indian, k, Whita, atc. //////////////////////////////////// |
| | (Specify only highest grade completed) ((| ECEDENT'S U | ork done di | | | ıa | 18b. | KINO OF BUS | INESS/IN | DUSTRY | |
| COMPLETED | Elamentary/Secondary (0-12) Collega (1-4 or 5+) 6 TH | e. Do NOT use | retired.) SEWII | | | | | | | | |
| 200 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOT | | | iddle, Maiden | | | |
| BE | MICHAEL STEIN | | | | | | | EARMAN | | | |
| 2 | 198. INFORMANT'S NAME (Type/Print) WILLIAM LOVETT | 96. MAILING A 51 31 | | | | | | | | | o, MD. 21088 |
| | 20s, METHOD OF DISPOSITION 20b. PLACE | E OF DISPOSE | | | | | | | | | own, Stata |
| | | DLAWN | | | | | | BALT | IOMI | RE, I | MD. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE |) | A | . A] | LAN S | SEITZ | z, JR | . FUNI | ERAL | HOM | E . 21211 |
| | 23. PART I. Enter the diseases, or complications that caused the | | | | | | | | | | Approximata |
| | ahock, or heart fallure. List only ona cause on aach lin IMMEDIATE CAUSE (Final | | | - | | | | | | | Interval Between Onset and Death |
| | disease or condition a. Congressive out to (or as a consi | Hea | aut | + | 41/6. | re | | | | | 3 Konth |
| _ | OUE TO (OR AS A CONSI | EOUENCE OF) |): | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | EOUENCE OF) |): | | | | | | | | |
| S | CAUSE (Disease or Injury | | | | | | | | | | |
| | that initiated events resulting in death) LAST | EOUENCE OF |): | | | | | | | | |
| | d | | | | | | | | | | |
| CAL | PART II. Other eignificant conditions contributing to dash but not | reaulting in | n tha un | derlyin | g cause | given in | Part I. | 24a. WAS AN PERFOR | RMED? | 24 | b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| EDIC | Mary | | | | | | | 1 TYES 2 | NO | | OF DEATH? |
| PHYSICIAN: MEDI | | | | | | | | | | | 1 123 232 110 |
| SIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | | | LACE OF C | DEATH (Ch | heck only on | 0) | | | |
| YSIC | 1 YES 2 NO 1 Inpatient 2 ER/Outpatient | 3 🗆 DOA | | ing Hon | | asidence | 8 🗆 Otha | | | | |
| ву Рн | 27. MANNER OF OEATH 1 Netural 5 Pending 2 Accident Investigation 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | | | JURY AT ORK? YES 2 [| _ NO | 28d. DES | CRIBE HOW I | NJURY O | CCUREO | |
| | 3 Suicide 8 Could not be building, etc. (Specify) 4 Homicide determined | home, farm, st | treet, fact | ory, offic | ia . | | | ATION (Street or Town, State) | | er or Rural | Route Number, |
| COMPLETED | 29e. CERTIFIER (Check only one) | | | | | | | | | | |
| SO | 2 MEDICAL EXAMINEN: On the Deals of examination and/o | or Investigation | n, in my o | pinion, | death occu | ired at the | e time, date | end place, at | nd dua to | the cause | (a) and manner as stated. |
| 8 | 29b. SIGNATURE AND TITLE OF CESTIFIER 10 | | | | 29c. LIC | 23 | o76 | | 29d. DA | | ED (Month, Day, Year) |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (IT | - | | 120 | 6 | 7> | | - M. | 0 | 212 | 17 |
| | 31. DATE FILED (MONTH, Day, Year) 32. REGISTRAR'S SIGNATURE | Fu | 175 | 100 | (| 1> | ace | 114 | | 412 | - () |
| | DEC 14 1990 Suha Tavidan Rand | .00_ | | | | | | | | | 1 |
| | | | | | | | | | | | DHMH-18 Rev 1/89 |



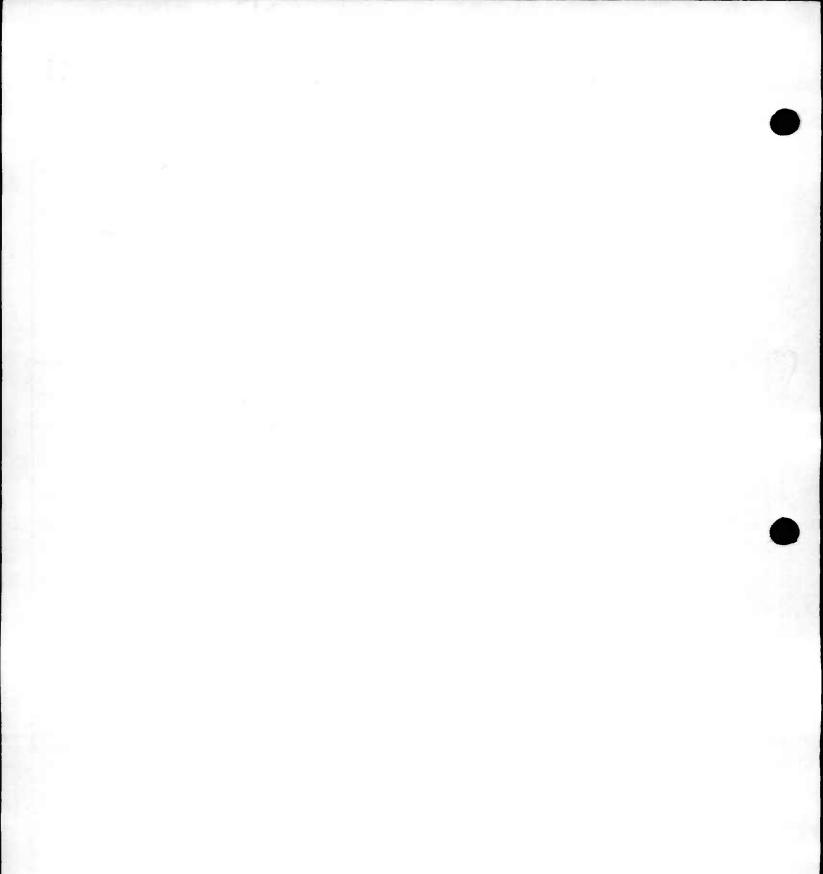


21203-3146

BALTIMORE, MARYEA TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-hours after death. Page 6 may be retailed to TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at

| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH DAY | YEAR 3. TIME OF DEATH |
|---------------|---|--|--|--|---|
| | RUTO E, AIRN | | | 12-10- | 90 M |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birth 1 □ M 2 □ P 8. AGE (In yrs. lest birth | | EAR IF UNDER 24 HRS. NYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) |
| | Sa. FACILITY NAME (If not institution, give street and number) | 9b. CITY, TO | WN OR LOCATION OF D | EATH 9c. CO | DUNTY OF DEATH |
| OR O | INNS of EVERGREEN NUISI | tone 6 | Allimor | o City | |
| 딦 | RESIDENCE OF DECEDENT | c. CITY, TOWN OR L | OCATION | | 10d. INSIDE CITY |
| DIRECTOR | In ary land | BAIL | more | | 1 Pes 2 No |
| M | 10e. STREET AND NUMBER | 5B. | 10f. ZIP CODE | 10g. C | TIZEN OF WHAT COUNTRY? |
| FUNERAL | 721 DRUID PARKLAKE DRIVE | e | | | U.S.H. |
| | 11. MARITAL STATUS 1 □ Never Married 2 □ Married IF VES, GIVE WAR OR DATES | If yo | BECENDENT OF HISPA B, specify Cuban, Maxic YES 2 ANO Speci | | - 14. RACE — American Indian, Black, Whita, etc. |
| 84 | 3 - Midowed 4 Divorced | '' | res z ga-no spaci | vy. | BIACK |
| 밀 | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16a. DECEDE (Give kin | ENT'S USUAL OCCU nd of work done durin VOT use retired.) | PATION ng most of working | 16b. KIND OF BUSINESS/ | INDUSTRY |
| COMPLETED | College (1-4 or 5+) | USE W | 11 | | |
| ŏ. | 17. FATHER'S NAME (First, Middle, Lest) | 200 | 7 | AME (First, Middle, Malden Surname | 9) |
| BE C | Andrew F. BRooks | | FAN | nie E, C | OOK |
| ဥ | 19a. INFORMANT'S NAME (Type/Print) 19b. MA | ULING ADDRESS (SI | treet and Number or Rural | Route Number, City or Town, State, | Zip Code) |
| _ | 20a. METHOD OF DISPOSITION 20b. PLACE OF D | OLA BEN | TQLOCK of cornetery, crematory or | 20c, LOCATION | — City or Town, State |
| | 20s. PLACE OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D 20s. Place OF D | 105 MA | En RAFI | BALT | Co. Ma |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | 22. NAI | ME AND ADDRESS OF F | ACTUTY SS FUNCE | ral Home |
| | Joseph J. Kuss | 22 | 22 W. M | ath Aug. B | 215 And 21216 |
| | 23. PART I. Enter tife diseases, or complications that caused the death. shock, or heart failure. List only one cause on each line. | Do not enter the | moda of dying, su | ch as cardiac or respiratory | arrest, Approximata interval Batween |
| | IMMEDIATE CAUSE (Final | | 0 0 | 1. 110. | Onset and Death |
| | disease or condition resulting in death) a. DUE TO (OR AS A CONSCOUEN | ng c | T DI | adder | |
| _ | A S | C (/ 1) | | | i i |
| 2 | Sequentially list conditions, if any, leading to immediate | ICE OF): | | | |
| <u></u> | cause. Enter UNDERLYING CAUSE (Disease or Injury | | | | |
| CERTIFICATION | that initiated events resulting in death) LAST | ICE OF): | | | |
| | d | | | | |
| MEDICAL | PART II. Other algorificant conditions contributing to death but not resul | iting in the unde | rfying cause given in | Part I. 24s. WAS AN AUTOP: PERFORMED? | AWAILABLE PRIOR TO |
| | | | | 1 YES 2 NO | OF BEATH! |
| | | | | - | 1 TYES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | 28. PLACE OF DEATH (C | theck only one) | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpatient 3 0 | OTHER: | Home 5 - Residence | 8 Other (Specify) | |
| | 27. MANNER OF DEATH 1 | INJURY | e. INJURY AT WORK? | 28d. DEŞCRIBE HOW INJURY | OCCURED |
| BY | 2 Accident Investigation | | YES 2 NO | 26f. LOCATION (Street and Nurr | shar or Build Bouts Number |
| COMPLETED | 3 Suicide 6 Could not be determined 28e. PLACE OF INJURY — Al home, (| | , once | City or Town, State) | ioer or noter note number, |
| J.E | 29a. CERTIFIER (Check only) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death of | occurred at the time | date and place, and du | e to the cause(s) and manner as | stated. |
| NO. | one) 2 MEDICAL EXAMINER: On the basis of axamination and/or inves | | | | |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 29c. LICENSE NU | JMBER 29d. (| DATE SIGNED (Month, Day, Year) |
| TO BE | Ometan M Malem | | D15 | 503 | 12/11/20 |
| F | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 | (Type, Print) | Solphin | St Balto | - MO217/7 |
| | 31. DATE FILED (Month, Day, Year) P. 62. REGISTRATE SURVEY P. | 50/ | (111/1/10 | 9 1270/6 | 110/0/01 |
| | DEC 14 1990 Grain favidson- Maria | | | | - 1 |



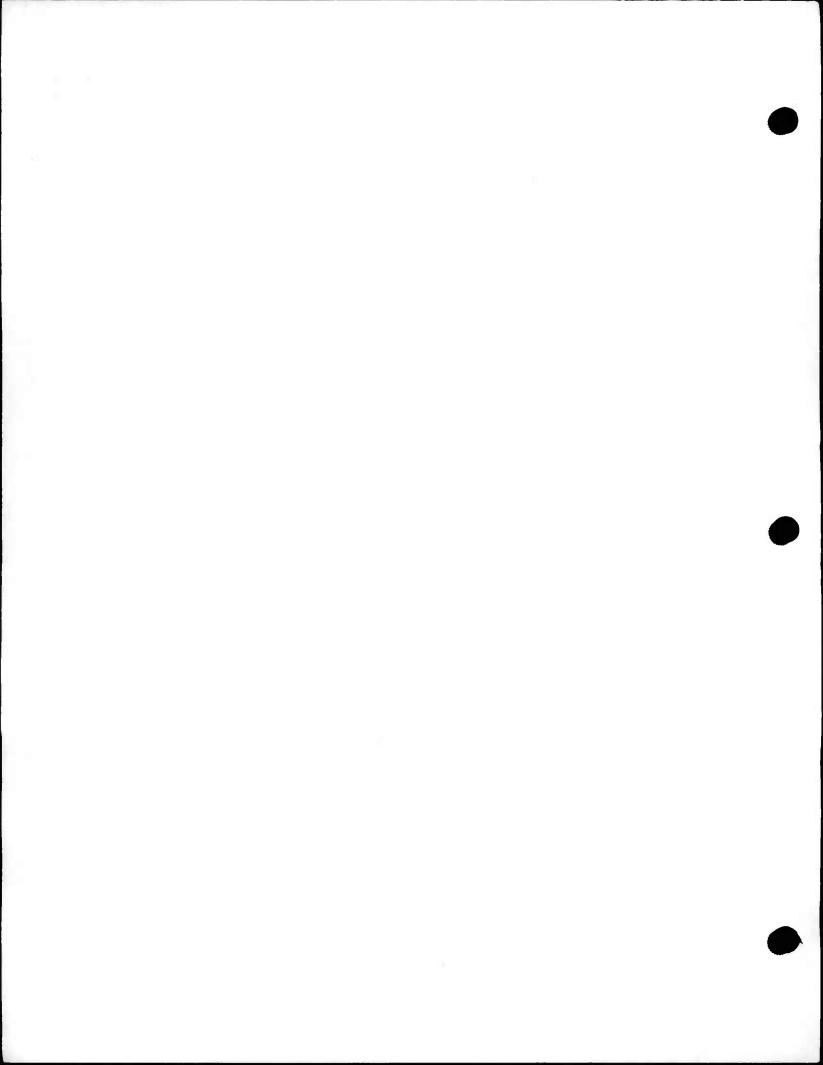
| the hos | e detache | t once. | |
|--|--|--|----|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacht has find within 72 hours after death with the State Debt, of Health and Mental Horiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
| y be r | page 5 | pe n | |
| е 6 т | ector, | must | |
| h. Pag | eral dir | niner | |
| r deat | al. | ехап | |
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| 24 nou | filled I | he m | |
| within | pletely | ent, t | |
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| ficate | physic ne pric | her tr | |
| h certi | Hvaie | or of | |
| e deat | the atte | Jury, | |
| that th | band th | any Ir | |
| quires | n signi | SWO! | |
| aw re | as bee | 23 sh | |
| I: The | cate hi | item | |
| SICIA | certiff h the | d, 0r | |
| G PHY | er this | narke | |
| ENDIN | DR: Aft | B Is n | |
| JR ATT | IRECTC | em 2 | |
| ITAL 0 | RALD | = | |
| HOSP | FUNE | TANT | |
| O THE | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first within 29 hours after death with the State Dent, of Health and Mental Hydiene prior to bunial, cremation, or removal. | MPOR | |
| P- | | | Į. |

| | FOR STATE | STATE OF MARYLA | | IENT OF HEALI ATE OF DE | | | 9 | 0 34212 | |
|--|--|---|--|--------------------------------------|--------------------------------|--|------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Bernard J. | Amrhein | CERTIFIC | AIE OF DE | 2. | DATE OF DEATH DAY DECEMber 10 | , 1990 YE | ar 3. TIME OF DEATH | |
| | | 1 XM 2 □ F 8 | 37 YRS. MO | NTHS DAYS HOUR | MIN. | Mar.8,190 | 3 M | BIRTHPLACE (State or Foreign Country) | |
| тон | 90. FACILITY NAME (If not institution, give structured in the stru | | 96 | Baltimore | | | 9c. COUNTY Ci | ty | |
| DIRECTOR | Md . 10e. STREET AND NUMBER | | | altimore | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 5511 Summerfield / | Venue | U.S. ARMED | 101, ZIP 0 212 | 206 | ORIGIN? (Specify Yee | USA | OF WHAT COUNTRY? RACE — American Indien. | |
| B | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 TYES IF YES, GIVE WAR OR DATE | 2 X NO | | uben, Mexicen, P | | | RACE — American Indien, Black, White, etc. | |
| COMPLETED | 15. DECEDENT'S EDUC. (Specify only highest grade of Elementary/Secondery (0-12) | ATION completed) College (1-4 or 5+) | 16e. DECEDENT'S USI (Give kind of work life. Do NOT use re Metal CY | done during most of w tired.) | orking | Martin | | | |
| ш | 17. FATHER'S NAME (First, Middle, Last) Phillip Amrhein | | Hetal of | 18. A | | (First, Middle, Meiden Christia | Sumame) | Lua | |
| TO B | 190. INFORMANT'S NAME (Type/Print) Edith S. Amrhein | | 5511 9 | oness (Street and Nur Cummerfie) | nber or Rural Roun Id Avenu | ne Number, City or Town Je Baltim | ore, M | d. 21206 | |
| | 20e. METHOD OF DISPOSITION 1 | val from State | cother place) andens of | | ec.13, 1 | 1990 Bal | | or Town, Stats | |
| | ▶ James F. Glado | len James f., | | Leonard | J. Ruc | ck Inc. 5 | | rford Rd.21214 | |
| | IMMEDIATE CAUSE (Fine) | ist only one cause on as | ech line. | | | VI 00-E | | Interval Between Oneet end Deeth | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events b. OUE TO (OR AS A CONSEQUENCE OF): C. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERT | resulting in death) LAST d. PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | |
| MEDICAL | | | | | | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| PHYSICIAN: MEDICA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ANO | HOSPITAL: 1 Inpatient 2 ER/Outpu | atient 3 DOA 4 | 28. PLACE (THER: | DF DEATH (Check | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | PF 28c. INJURY A WORK? M 1 YES | 2 NO 28 | 28d. DESCRIBE HOW INJURY OCCURED | | | |
| | 3 Suicide 6 Could not ba 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | ify) | | | 81. LOCATION (Street a City or Town, State) | × v | Pural Houte Number, | |
| COMPLET | (Check only | | | In my opinion, death o | occured at the time | ne, date end place, sn | d due to the c | suse(s) and manner as stated, | |
| 29d. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Michael Minninsohn MD 8813 Waltham Woods Road Baltimore, Maryland 21234

31. DATE FILED (Month, Day, Year)
DEC 1 4 1990 32. REGISTRAR'S SIGNATURE

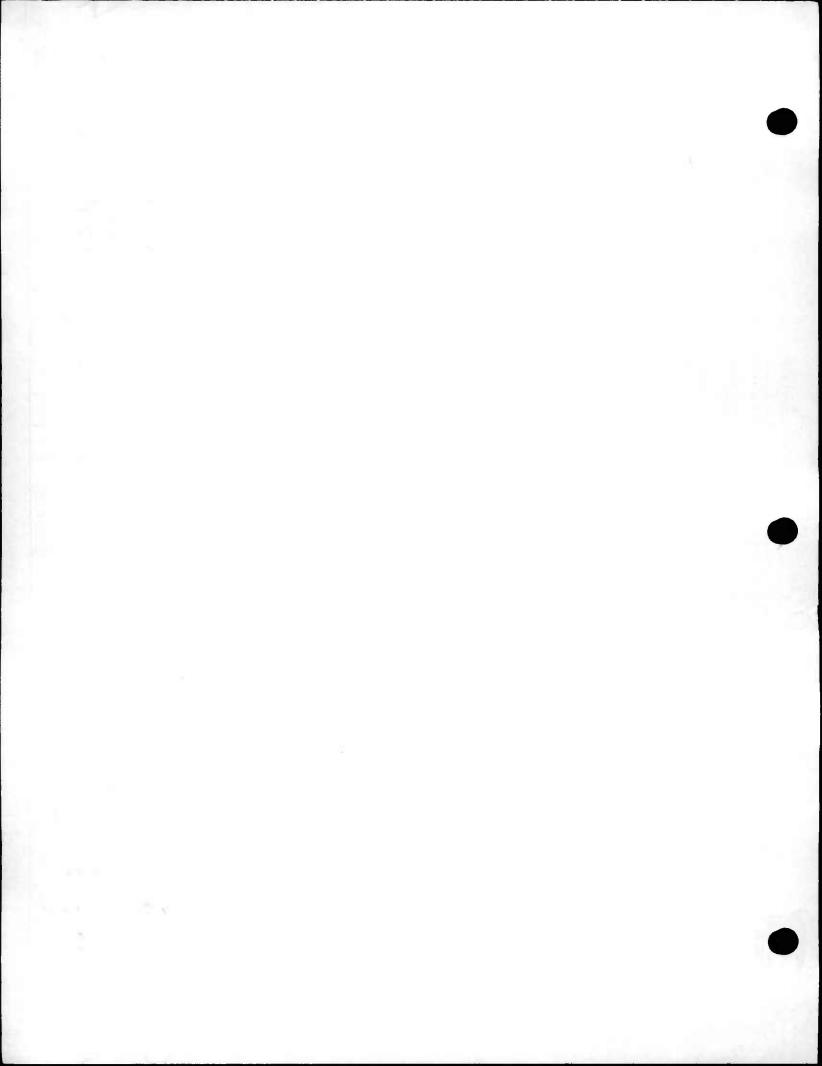


DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | ttending physician. | e as the burial-transit permit. Pages 1, 2, 3 should | |
|---|--|--|--|
| Î | nours after death. Page 6 may be retained by the hospital or | ed in by the funeral director, page 5 should be detached for u or removal. | medical examiner must be notified at once. |
| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nous after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should he filed with the State Debt. of Health and Mental Mygiene prior to burial, cremation, or removal. | IMPORTANT. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: | TO THE FUNERAL DIRECTOR: After this certifical be filed within 72 hours after death with the Sta | IMPORTANT: If item 28 is marked, or ite |

| 1 | 1 - STATE OF MA | | / DEPARTM | | EALTH AND M | ENTAL HYGIE | | | | |
|---|--|--|---|----------------------------|--|---|----------------------------------|-------------------------|--|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) LUANITA C. BEN | | | | | 2. DATE OF DEATH MONTH | | 70 | OME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 1 M 2 F 9a. FACILITY NAME (If not institution, give street and number) | 6. AGE (In yrs. | YRS. MO | OL CITY, TOWN (| HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 9c. COUNTY | Country) OF OEATH | | |
| DIRECTOR | SUMMITT NURSING HOME | | | BALTIN | IORE | | BALTII | MORE | COUNTY | |
| | MARYLAND BALTIMORE | | BALTII | OWN OR LOCAT | TION | | 10d. | LIMITS? X YES 2 1 NO | | |
| LONEHAL | 936 VANDERWOOD ROAD | | | 101 | 21228 | | U.S | | COUNTRY? | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. WAS DECEDENT FORCES? 1 IF YES, GIVE WA | YES 2 | | If yes, sp | ENDENT OF HISPANIC ecity Cuban, Mexican, 2 NO Specify: | | fes or No— 14 | Specify: | American Indian, ilta, etc. | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12thGrade | | DECEDENT'S US (Give kind of work life. Do NOT use no Homem | done during mo etired.) | DN st of working | 16b, KIND OF E | | | | |
| DE COM | 17. FATHER'S NAME (First, Middle, Last) 18. MOTH | | | | 18. MOTHER'S NAM MYRTLE G | E (First, Middle, Maid | en Surname) | | - 5 | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) ROBERT BEMAN | ROBERT BEMAN 936 VANDERWOOD ROAL | | | | nl Route Number, City or Town, State, Zip Code) D, BALTIMORE, MD 21228 | | | | |
| | 20s. METHOD OF DISPOSITION 143 Burlai 2 Cremation 3 Removal from State 4 Donation 8 Other (Specify) GARRISON FOREST CEMETE. | | | | | Ow | ings Mi | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIM | | | | | | iore, | MD 2122 | | |
| | 23. PART I. Enter the disease, or complications that ehock, or haert failure. List only one caus IMMEDIATE CAUSE (Finel disease or condition resulting in desth) DUE TO (6) | e on each i | ine. | | Lun | | spiratory arres | t, | Approximate interval Between Onset end Deati | |
| OFFILI ICALION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | PART II. Other eignificent conditions contributing to death but not resulting in the underlying ceuse gives the second se | | | | | 1 in Part i. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | | | Ab. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| THE SIGNAL MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 PNO 1 Inpution 2 ER/Outpation 3 DOA 4 Provising Home 5 Residence 6 Other (Specify) | | | | | | | | | |
| | 1 Netural 5 Pending (Month, De | 7. MANNEPOF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 1 Netural 5 Pending M 1 YES 2 NO | | | | | 28d. OEŞCRIBE HOW INJURY OCCURED | | | |
| 28a PI ACE OF INJURY At home form street factory office. 284 LOCATION (Street and Number or Pivol Books M | | | | | | | Number, | | | |
| COMPLEIED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of axi | | | | | | | | d manner as stated. | |
| 4 | 296. SIGNATURE AND TITLE OF CERTIFIER | aure |)20 - | 5 | 29c. LICENSE NUM D 13 | | | | nth, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUS | OF DEATH (| TEM 27) (Type, P) | | rsín | g Hon | u Le | Ball | - mad | |
| | 31. DATE FILED (Month, Day, Year) DF (4 199) 32. REGISTRAL | P'S SIGNATUR | Randella | | | | | 21 | 228 | |

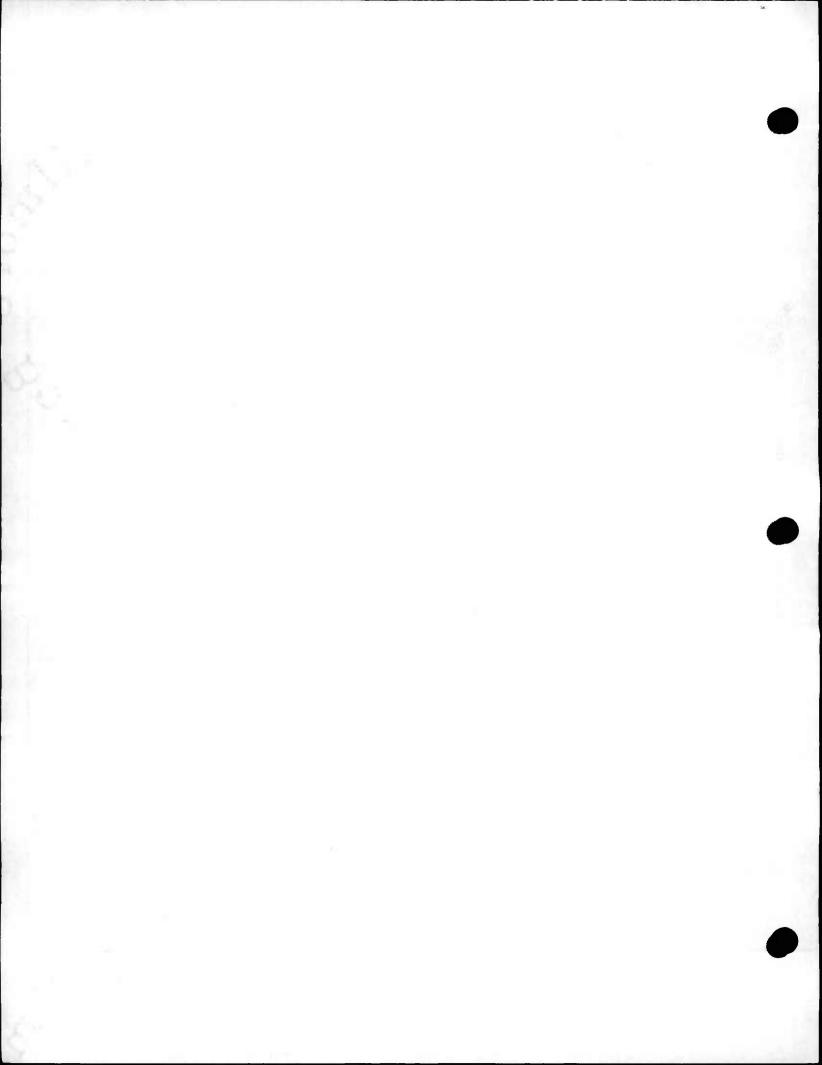




ansit permit. Pages 1, 2, 3 should

| | FOR STATE | | STATE OF N | | | | | EALTH AND I DEATH | MENT | | - | U | 34214 |
|---|---|--------------------------------|-----------------------|-------------------|----------------|---------------|---------------------|--|---------------------------------|--------------------------------|---------------|-----------|--|
| | REGISTRAR 1. DECEDENT'S NAME (First, | adulate desail | | | ERIII | ICATI | - OF | DEATH | 2.04 | REG. NO. | _ | 1, | TIME OF DEATH |
| | | | 1.1 | | | | | | MON | ITH DAY | | AR | |
| | 4. SOCIAL SECURITY NUMB | adys | 5. SEX | 6. AGE (In yrs. I | Blur | IF UNDER | - WEAR | IF UNDER 24 HRS. | | 2 11 E OF BIRTH | 90 | _ | 12:04 a ^M ACE (State or Foreign |
| | 22 C-11 - 1-1-1-1-1 | | 1 M 2 X F | A CONTRACTOR | YRS. | MONTHS | DAYS | HOURS MIN. | (Mo | nth, Day, Year) | | Country) | |
| | 112-32-0310 | | | / | U Ins. | | | | | <u> 29/1920</u> | | | York |
| | 9a. FACILITY NAME (If not in | | | | | 96. CITY | , TOWN (| OR LOCATION OF DE | | | 9c. COUNTY | OF DEAT | н |
| Greater Baltimore Medical Center Towson RESIDENCE OF DECEDENT 100. STATE 100. STATE 100. CITY, TOWN OR LOCATION Baltimore Baltimore | | | | | | | | | | Balt | timore | | |
| 입 입 | 10e. STATE | 10b. COUNT | Y | | 10c. CI1 | ry, town | OR LOCAT | TON | | | | 10 | d. INSIDE CITY |
| MD Baltimore | | | | | | | | imore | | | | ,X | LIMITS? |
| | 10e. STREET AND NUMBER | | ur ormore | | | - | | . ZIP COOE | | | 10g. CITIZEN | OF WHA | T COUNTRY? |
| | 5706 Highga | ate Dr | ive | | | | | 21215 | | | US | Α | |
| 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Year or No.— 14. RACE | | | | | | | | RACE - | American Indian, fhite, atc. | | | | |
| | 1 Never Married 2 | | FORCES? 1 | YES 2X | No | | | ecify Cuben, Mexica 2/ NO Specif | | o Rican, etc.) | | Specify: | /hite, atc. |
| à l | 3 Wildowed 4 Divo | rced | | | | | | XX | | | | | BLACK |
| | | EDENT'S EDU y highest grade | | | DECEDENT'S | | | ON sst of working | 1 | 6b. KIND OF BUS | INESS/INDUST | RY | |
| u, | Elementary/Secondary (0 | | College (1-4 or 5 | +) | Ille. Do NOT L | use retired.) | | | | | 6 1100 | | |
| <u> </u> | | | 4yr | s RE | GIST | EREL |) : [| IURSE | | HOLLI | 2 HO? | PII | AL |
| COMPLET | 17. FATHER'S NAME (First, M | | | | | | | 18. MOTHER'S NA | | | , | | |
| BE | JOSEPH W | ILLI | AMS | | | | | GEOR | GIA | NNA WI | LLIAN | 15 | |
| 0 | 19a. INFORMANT'S NAME (| | | | | | | and Number or Rural | | | | | 4D 01012 |
| | DONNIE WA | | | | | | | | AVE | | | | 1D. 21213 |
| | 20 METHOD OF DISPOSIT 1 ☑ Burial 2 ☐ Crematic | ION on 3 ☐ Ren | noval from Stata | 20b. PLAC | Place) | N) MOITIEC | ama of ce √I∩D 1 | AL CEM | | | UTUS. | | * |
| | 4 Donation 5 Other | | | ARD | 0103 | | | | | ARD | 0103, | 111 | • |
| | 21. SIGNATURE OF FUNERA | IL SERVICE LI | CENSE | 1 | | 22. | NAME A | ND ADDRESS OF FA | CILITY | | | | |
| 3 | Che | hw | mar | ch | | | MM. | .MARCH | F. | H. 110 | 1 E. | NOF | RTH AVE. |
| ahock, or heart fallure. Liet only one ceuse on each line. | | | | | | | | Approximate interval Between Onset and Death | | | | | |
| | disease or condition resulting in death) e. Cardiac Arrest oue TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| _ | Dehydration Z wed | | | | | | | | Curchy | | | | |
| CERTIFICATION | Sequentially list condit if any, leading to imme | | | (OR AS A CON | SEOUENCE | OF): | | | | | | | (H |
| 8 | cause. Enter UNDERLY CAUSE (Disease or Inju | ING | - Pancr | eatic (| CA | | | | | | | | 6 months |
| | that initiated events | | DUE TO | (OR AS A CONS | SEOUENCE | OF): | | | | | | | |
| E | reaulting in death) LAS | " | d | | | | | | | | | | |
| 0 | PART II. Other algolfica | ent conditio | na contributing to | dasth but no | ot resulting | in the u | ndariyir | g cause given in | Part i | 24a, WAS AN | AUTOPSY | 24b. W | PERE AUTOPSY FINDINGS |
| 5 | | | 7 | | V | | | | | PERFOR | MED? | 0 | MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | | 1 YES 2 | JUIO | | F DEATH? |
| Σ | | | | | | | | | | | | ' | YES 2 NO |
| A A | 25. WAS CASE REFERRED 1 | TO MEDICAL | | | | | 26 0 | LACE OF DEATH (C | heck onli | (one) | | | |
| PHYSICIAN: MEDICA | EXAMINER? | | HOSPITAL: | FR/Outpath | 3 DO4 | OTHE | R: | | | | | | |
| ž | 27. MANNER OF DEATH | | 26a. DATE O | F INJURY | 28b. T | ME OF | 28c. IN | ne 5 - Residence | _ | TINET (Specify) DESCRIBE HOW I | NJURY OCCUP | RED | |
| | | Pending | | Day, Year) | | NJURY | | ORK? YES 2 NO | | | | | |
| À | Y ☐ Accident 3 ☐ Suicide | Investigation | 28s. PLACE | OF INJURY — AI | home, farm | , street, fe | | | 281.1 | OCATION (Street) | and Number or | Rural Rou | ite Number, |
| | 4 Homicide | Could not be determined | building | , etc. (Specify) | | | | | | City or Town, State) | | | |
| | 29a. CERTIFIER | TIEVING BUV | SICIAN: To Jhe best o | d my knowledge | doub annu | mad at the | Here det | a and alone and de | n In Iha | acusalst and ma | | | |
| COMPLETED | (Critical Offin) | | | | | | | | | | | | and manner as stated, |
| BE | 296. SIGNATURE AND TITL | E OF CERTIFIE | ER | - | | | | 29c. LICENSE NU | MBER 73 c |) | 29d. DATE S | IGNED (A | Monthy Day, Year) |
| ဥ | 30. NAME AND ADDRESS C | OF PERSON W | HO COMPLETED CA | JSE OF DEATH (| ITEM 27) (Ty) | pe, Print) | | | 1 | | | 1/- | , . |
| | Gary Cohe | n.M.D. | | | | | | | | | | | |
| ij | 31. DATE FILED (Month, Day | ; Y6ar) | | AR'S SIGNATUR | | | | | | | | | |
| | DEC 14 19 | 90 4 | the Davidson | - Manda | L | | | | | | | | |
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DHMH-18 Rev 1/89



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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF OEATH 12 12 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. IF UNDER 1 YEAR 3 03 9c. COUNTY OF CEATH BALTO. HOSP. DIRECTOR 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MORE 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER IN. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 20 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No 14. RACE - American Indian, Black, White, etc. If yes, specify Cuben, Mexican, Pu 1 YES 2 NO Specify: 1 Never Married 2 Married YES, GIVE WAR OR DATES Specify: Black B 3 Widowed 4 Divorced COMPLETED 15. OECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 16b. KIND DF BUSINESS/INDUSTRY ary/Secondery (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Geysta BE 9 acquelin 7438 Woodbind enation 5 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 300 walash 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate ahock, or heart fallure. List only one cause on each line. Interval Batwe **Onset end Death** IMMEDIATE CAUSE (Final CARDIO GENIC disease or condition SHOCK resulting in death) DUE TO (OR AS A CONSEQUENCE OF): INFARCTION MYOCARDIAL CERTIFICATION Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events OUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMEO? 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO PHYSICIAN: MEDICAL COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO estient 2 - ER/Outpetient 3 - DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 27. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d. DEȘCRIBE HOW INJURY OCCURED 1 Netural 5 Pending 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 3 Suicide 8 Could not b COMPLETED 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my kno ath occurred at the time, date and place, and due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basic of e m, in my opinion, death occured at the time, date end place, and due to the cause(e) and manner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, BE 20 INTERN 2

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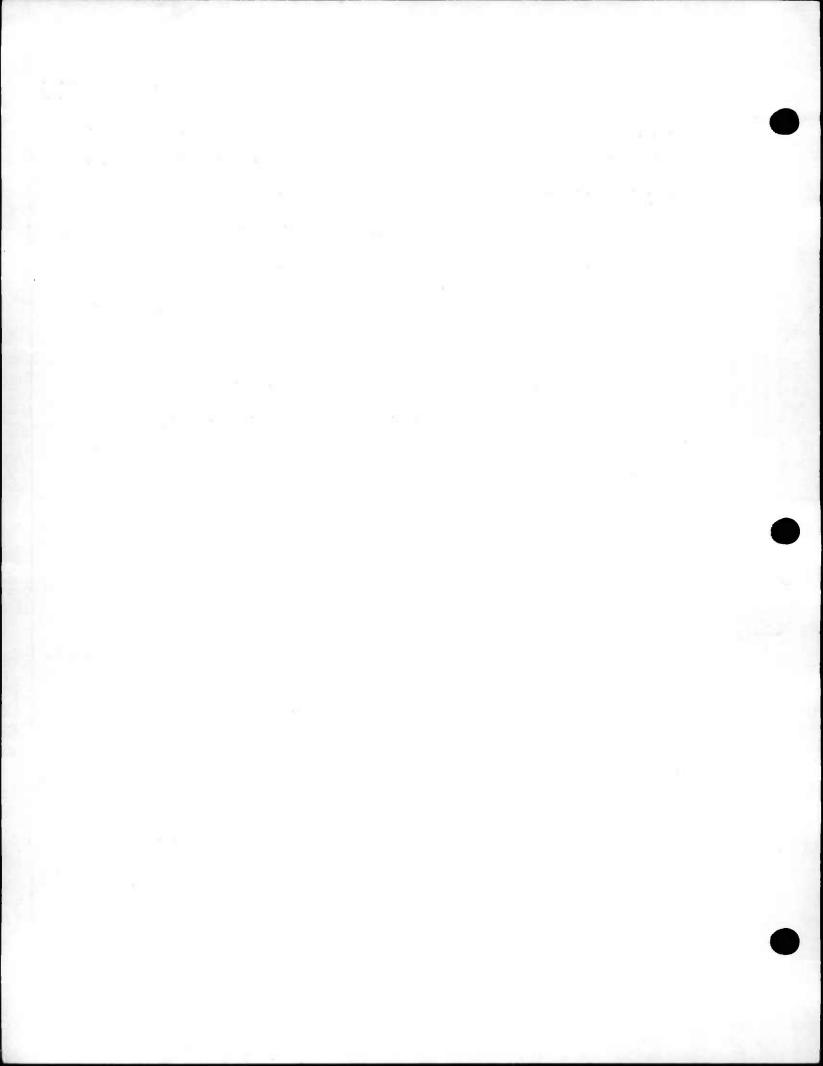
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF CEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)

4 1990 32. REGISTRAN'S SIGNATURE

a Devidson

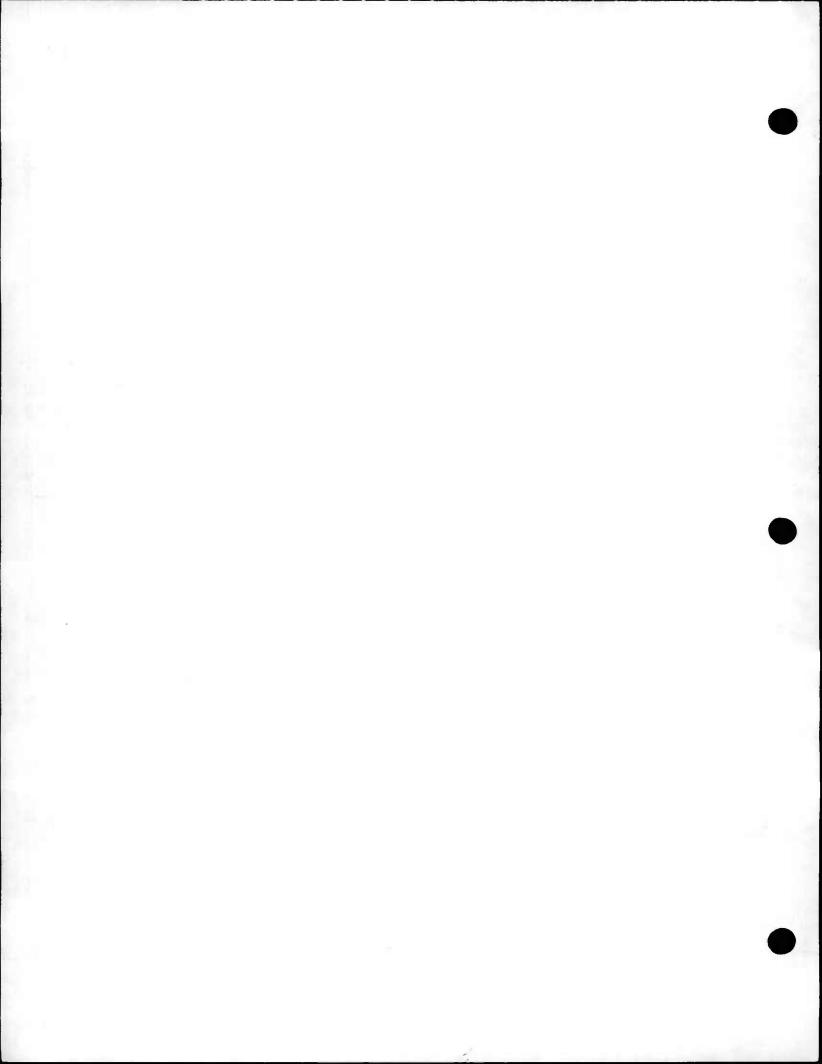
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| STATE OF MARYLAND | / DEPARTMENT | OF HEALTH | AND | MENTAL | HYGIENE |
|-------------------|--------------|-----------|-----|--------|----------|
| | CERTIFICATE | OF DEAT | Ή | | REG. NO. |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | TMENT OF | HEALT F DE | H AND I | MENTA | HYGIEN | E | | | |
|-------------------------|--|---|-----------------------------------|--|---|-------------|-------------------------------------|--|---------------------|--------------------------------|---|--|
| | 1. OECEDENT'S NAME (First, Middle, Lest) Cathilda Gai | 1 BERGER | | | | | 2. DATE MONTO DEC | of DEATH DA | "1990 ' | 3. 1 EAR] | TIME OF DEATH L:00 a m | |
| | 4. SOCIAL SECURITY NUMBER 219-26-8495 | 1 🗆 M 2 🔯 F | fn yrs. lest birthdey) 52 yrs. | IF UNDER 1 YEA | | DER 24 HRS. | 7. DATE (Monto May | of BIRTH | .938 1 | BIRTHPLA Country) VOT. t | ce (State or Foreign h:Carclin | |
| TOR | 90. FACILITY NAME (If not institution, give s Franklin Squa RESIDENCE OF DECEDENT | | 1 | 9b. CITY, TOV | | CSSV | | | Balti | | , md Co. | |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNT | Baltimore | | Y, TOWN OR LO | | sedal | l e | | | - | I. INSIDE CITY LIMITS? YES 2 (2) No. | |
| ERAL | 100. STREET AND NUMBER 1213 Sixty-Tr | iid Street | | 10f. ZIP COOE 21237 | | | | 10g, CITIZEN OF WHAT OUSA | | | COUNTRY? | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR ON | | If yes | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Spill yes, specify Cuben, Mexican, Puerto Rican, 1 YES 2 NO Specify: | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondary (0-12) | CATION o completed) College (1-4 or 5+) | (Give kind of silfe. Do NOT us | DENT'S USUAL OCCUPATION kind of work done during most of working on NOT use relifered.) CCOUNTAINT | | | | | | | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) Jame'S | Paige | | | 18. M | | ME (First, | Middle, Maiden K | Sumeme) Cer∈1 | | | |
| TO B | 196. INFORMANT'S NAME (Type/Print) Joann Nevak | | | | | | | Number, City or Town, State, Zip Code) Street BAlto.Md.21237 | | | | |
| | 20a, METHOD OF DISPOSITION 1 & Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | | | wn Cemetery Baltim | | | | | | | | |
| | 21. 9 GNATURE OF FUNERAL SERVICE LA | -unulal | Home | | | lyFur | | lHome | 300M | AceA | ve.21221 | |
| ATION | IMMEDIATE CAUSE (Final | a. Metastatic DUE TO (OR AS A | ach line. | ancer | mode of | dyling, auc | h ee cer | diec or reepi | ratory erree | t, | Approximete Interval Between Onset and Death | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| BY PHYSICIAN: MEDICAL C | PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse g | | | | | PERFO | | | FORMED? S 2XXNO D | | RE AUTOPSY FINDINGS ALLABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | setlant 3 🗆 DOA | OTHER: | | F DEATH (C/ | | | | | | |
| / PHY | 27. MANNER OF DEATH 1 Netural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIR | IE OF 280 JURY | INJURY A' WORK? | Т | | SCRIBE HOW | NJURY OCCU | REO | | |
| | 2 Accident Investigation 3 Suicide 2 Could as the 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. L | | | | | | | 81. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| COMPLETED | one) | SICIAN: To the best of my know ER: On the bests of examination | | | | | | | | | nd menner ee stated. | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIE | | 29c. LICENSE NUMBER 837 | | | | 29d. DATE SIGNED (Month, Day, Year) | | | | | |
| 5 | Nada Kiwan, | | ranklin | | e Dri | ve, B | alti | more, | Md 212 | 237 | / | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATURE Handall | | | | | | | | | |



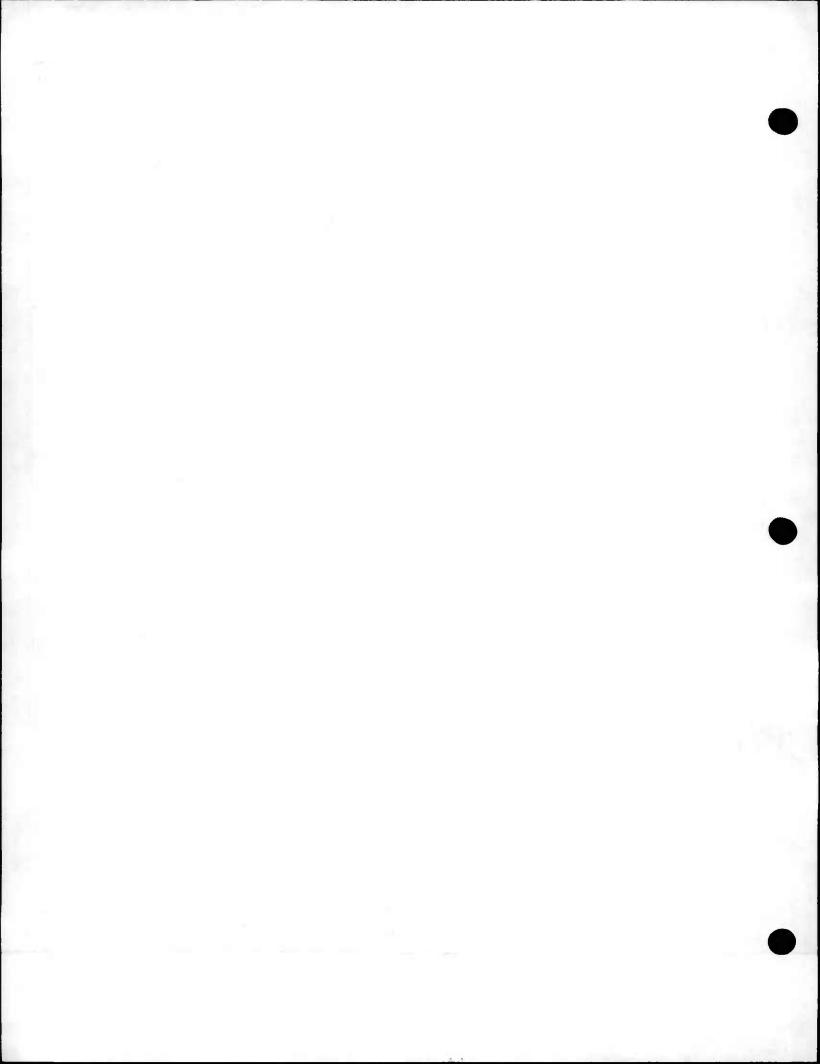
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

| | FOR STATE REGISTRAR | STATE OF MAR | YLAND / DEP/ | ARTMEN | T OF H | EALTH DEAT | AND N | MENTAL H | YGIEN EG. NO. | 70 | | 7211 | |
|-------------------|---|------------------------------------|--|------------------------|----------------|--|------------------|------------------|----------------------------|-------------------------------|---|------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Margaret | | | LARD | | 100 | 900 | 2. DATE OF MONTH | DEATH DA | Y YI | EAR 3. | TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. last birthda | y) | H 1 YEAR | IF UNDER 2 | 24 HRS. | 7. DATE OF | BIRTH ex. Year) | 6. | BIRTHPLA Country) | CE (State of Foreign | |
| | 213-34-5832 | 1 🗆 M 2 🌥 F | 94 . YAS | | | | | Oct. | 25 | 1895 | Ma | aryland | |
| ~ | 9e. FACILITY NAME (If not institution, give s | | 1 | 9b. CIT | | R LOCATIO | | | | 9c. COUNTY | | | |
| 2 | Franklin Squa | re Hospi | tal | Rossville | | | | | | BAL | TIMO | RE | |
| DIREC | Md . | Baltimor | 100. | CITY, TOWN | | SSEX | | | | | 1. INSIDE CITY LIMITS? YES 2 😾 NO | | |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 337 Oberle A | ve. | | | 10f. | . ZIP CODE | 212 | 221 | | 10g. CITIZEN OF WHAT COUNTRY? | | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 | YES 2 NO | 13 | If yes, spe | WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee If yee, specify Cuban, Maxican, Puerto Rican, etc.) 1 YES 2 NO Specify: | | | | | e or No- 14. RACE - American Indian, Black, White, etc. Specify: White | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | | T'S USUAL (of work done T use retired.) HOUSE | during mo: | st of working | 7 | 16b. Kil | SINESS/INDUS | TRY | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) | Ehrman | n | | | | | ME (First, Midd | | Surname) "Mail | .ey_ | | |
| 10 | Susan Rippel | | 19b. MAIL 73 | L2 R | idge | nd Number Road | or Rural F Ma | rrio | cky or Tow ttsv | n, State, Zip Co ille | Md. | 21104 | |
| | 20e. METHOD OF DISPOSITION © Burlel 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | NewCat | | | | | У | | cation — cm Altim | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIE | unlla | l Hon | | | elly | | | Home | 300MA | ceA | ve.21221 | |
| | 23. PART I. Enter the diseases, or ahock, or heart failure. | complications that ca | used the death. D | o not enta | r the mo | da of dylr | ng, sucl | h as cardiac | or respi | ratory arrest | t, | Approximsta Interval Between | |
| | | | | | | | | | | | | Onset and Death | |
| | | | as a consequence | , | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING | b | DUE TO (OR AS A CONSECUENCE OF): Myocardial infarction | | | | | | | | | | |
| FI | CAUSE (Disease or injury that initiated events | c | AS A CONSEQUENCE | | | | | | | | | | |
| ERTI | resulting in death) LAST | Left p | leural ef | fusio | n wi | th co | lla | pse of | lef | t lung | | | |
| CALC | PART II. Other eignificant condition | s contributing to dar | ith but not resulting | ng in the u | ındariyin | g cause g | iven in | Part I. 24 | Ia. WAS AN | | | PRE AUTOPSY FINDINGS | |
| PHYSICIAN: MEDICA | Sepsis pancreatitis | | | | | | | _ 1 | YES 2 | | CO OF | MPLETION OF CAUSE DEATH? YES 2 NO | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 28. PI | ACE OF DE | FATH (Ch | eck only one) | | | | | |
| SIC | EXAMINER? | HOSPITAL: | /Outpatient 3 DO | OTHE A 4 N | ER: | | | 6 Other (S | Specify) | | | | |
| ву РНУ | 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28e. OATE OF INJ (Month, Day, Y | | TIME OF INJURY M | 28c. INJ WC | URY AT DRK? YES 2 | | | | NJURY OCCUP | RED | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF IN building, etc. | JURY — At home, fer (Specify) | m, street, fe | ectory, offic | • | | | ON (Street Town, State) | end Number or | Rural Rout | e Number, | |
| COMPLETED | (Direction Start) | ER: On the best of my | | | | | | | | | | nd menner se stated. | |
| TO BE | 296. SIGNAY OF CERTIFIE | 10011 | and) | | | 29c. LICE | | | | | 06 | onth, Day, Year) | |
| F | 30. NAME AND ADDRESS OF PERSON WING GEORGE GEILS | MD 9000 F | ranklin S | Type, Print) Sq. Di | r. Ba | ilto. | MD | 21237 | | | | | |
| | 31. DATE FILED (Month, Day, Year) OFC 1 = 19 | 32. REGISTRAR'S | SIGNATURE MANGE | lett. | | | | | | | | | |



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| | REGISTRAR | | Ç | ENTIF | CALE | OF | DEAL | П | RI | EG. NO. | | | |
|---------------|--|-----------------------------|--------------------|-----------------------------|--|--------------------------|----------------------|-------------------------|------------------|-------------|--------------|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2 | DATE OF D | DA | Υ | YEAR | 3. TIME OF DEATH |
| | | | R00KS | | | | | | | 2-19 | 990 | | 10:56 A.M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | and the same | MONTHS I | DAYS | HOURS | 24 HRS. 7 | Month, Day | | _ | Country | PLACE (State or Foreign |
| - 1 | 218-46-4806 | 1 🗆 M 2 💢 F | 84 | YRS. | | | | | 7-30 | <u>-190</u> | | Md. | |
| _ | 9a. FACILITY NAME (If not institution, give s | street and number) | | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DE | | | | | | | | |
| 6 | Manor Care Ross | ville | | | Ross | Rossville Balto. | | | | | | | |
| [[| 10a. STATE 10b. COUNT | | | 10c. CIT | r. TOWN OR | TOWN OR LOCATION 10d. II | | | | | | 10d. INSIDE CITY | |
| DIRECTOR | Maryland Balt | timore | | Kin | ngsville | | | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | | 1 | <u>J</u> | _ | ZIP CODE | E | | | 10g. CIT | | HAT COUNTRY? |
| FUNERAL | 11511 Chapman Rd | | | | | 1 2 | 1087 | , | | | U.S | S.A. | |
| <u> </u> | 11. MARITAL STATUS | 12. WAS DECEDEN | | RMED | | S DECE | NDENT O | F HISPANIC | ORIGIN? (Sp | | | 14. RACE | American Indian, |
| | 1 Never Married 2 Merried | FORCES? 1 IF YES, GIVE W | | NO | 1 1 | yes, spe | cify Cubai 2 X NO | n, Maxican, Specify: | Puarlo Rican | , alc.) | | | , While, atc. |
| BY | 3 Wildowed 4 Divorced | <u> </u> | anace value | | | | | | | | | Whit | te |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | | 16a. D | ECEDENT'S Give kind of v | USUAL OCC vork done dui se retired.) | UPATIO | N t of workin | g | 16b. KIN | D OF BUS | INESS/IND | DUSTRY | |
| Ľ | Elementary/Secondary (0-12) | College (1-4 or 5 | -) | | | | | | 1 | | | | |
| 불 | 12 Yrs. | | | lomema | iker | | | | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | Mar | | E (First, Middle | s, Maiden | Sumame) | | |
| BE | Bernie Koons 19a. INFORMANT'S NAME (Type/Print) | | | | | 20.00 | | , | ute Number, C | | 01 . 71 | . 0. 1. | |
| 임 | Catherine Neuman | | | | | | | | gsvill | , | | | |
| | ENGLISHED STATE OF THE STATE OF | | | | SITION (Name | | | | 93 V I I I | | | City or Tox | un State |
| | 20e. METHOD OF DISPOSITION 1 V Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | noval from State | other s | tern | | 15/9 | | ratory or | | | | , Md. | vii, Statu |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | | - I MC3 | CETTI | | | | SS OF FACIL | LITY | - Du | , | , 110. | |
| | Roy H. Ca | ther | | | | | | | | | | | 04044 |
| | | | | | | | | | | | | | Ito.,Md. 21214 |
| | 23. PART I. Entar the diseases, or shock, or heart failure. | Liat only one cau | ise on aach lin | aatn. vo r a. | iot antar ti | na mod | a or dy | ing, such | aa cardiac | or reapi | retory ar | reat, | Approximata Interval Batwaan |
| I | IMMEDIATE CAUSE (Final disease or condition | R | | | | | | | | | | | Onset and Death |
| | reaulting in death) | a | (OR AS A CONSI | | èm | رو | 1 | | | | | | |
| | | 502 10 | (ON AS A CONSI | EODENCE O | r). | | | | | | | | |
| CERTIFICATION | Sequantially flat conditions, | b. DUE TO | (OR AS A CONSI | EOUENCE O | f): | | | | | | | | |
| ¥ | if any, laading to immediata cause. Entar UNDERLYING | _ | | | | | | | | | | | |
| Ĕ | CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A CONSI | EQUENCE O | f): | | | | | | | | |
| | reaulting in death) LAST | d | | | | | | | | | | | |
| | PART II. Other significant condition | ne contribution to | dooth but not | no estable es | la the und | a et al e a | | elian In Di | and I I ass | 1400.0.411 | AUTOPSY | 1 000 | WERE AUTOPSY FINDINGS |
| MEDICAL | PART II. Othan algumeant condition | is contributing to | death but not | reauting | in tha Uno | arrying | cause g | given in Pi | BIFT 1. 248 | PERFOR | | 240. | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | | | | | | | | | - 10 | YES 2 | □ NO | | OF DEATH? |
| × | <u> </u> | 7, | | | _ | | | | - 1 | | | | 1 TYES 2 NO |
| N. | 25. WAS CASE REFERRED TO MEDICAL | 1.0 | | | | | | | | | | | |
| PHYSICIAN: | EXAMINER? | HOSPITAL: | Service Services | | QTHER: | | ACE OF D | EATH (Checi | k only one) | | | | |
| ΙXS | 1 TYES 2 NO 27. MANNER OF DEATH | 1 Inpetient 2 | | 3 DOA 28b. TIM | - | _ | | | Other (Sp | | u ilimu oc | OUDED | |
| | 1 Natural 5 Pending | (Month, E | | | URY M | | RK? | | 28d. DEŞCRII | DE HOW II | NJURY OC | CURED | |
| B | 2 Accident Investigation | 28e PLACE C | F INJURY - AI | ome ferm | etrant factor | | | | 281. LOCATIO | N /Street / | and Numbe | or or Rumi F | nute Number |
| ED | 3 Suicida 6 Could not be 4 Homicide determined | building. | atc. (Specify) | č | straet, rector | y, other | | Ι. | | wn, State) | | ir ur nureirn | outs number, |
| <u> </u> | 29a, CERTIFIER | | ** | - | | | - | | | | | | |
| COMPLETED | (Check only | SICIAN: To the best of | 26.6 | 16.0 | | | | | | | | |) and manner as stated. |
| 8 | | | AUTHINION WILL'O | - mwesiigani | лі, ін іну ор | illion, G | | | | piaca, an | id dual to t | ma cause(a |) and manner as stated. |
| BE | 291. SIGNATURE AND TITLE OF CERTIFIE | R (| 20 | | | | 29c. LICI | ENSE NUMB | 9 3 | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 24 | The way | 113m | 7 11/17 | FM OT T | D-(-4) | | ι | ハヿし | 12 | | | 10 | 13/40 |
| | | HO COMPLETED CAU | | | | اادا | МН | 21226 | | | | | |
| | 31. DATE FILED Minust Designed 404 | ,-M.D. 96 | ID DELGIF | Charles of the | erry i | all | , I'U. | ۷ ۱۷۵۵ | | | | | |
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BALTIMORE, MARYLAND 213

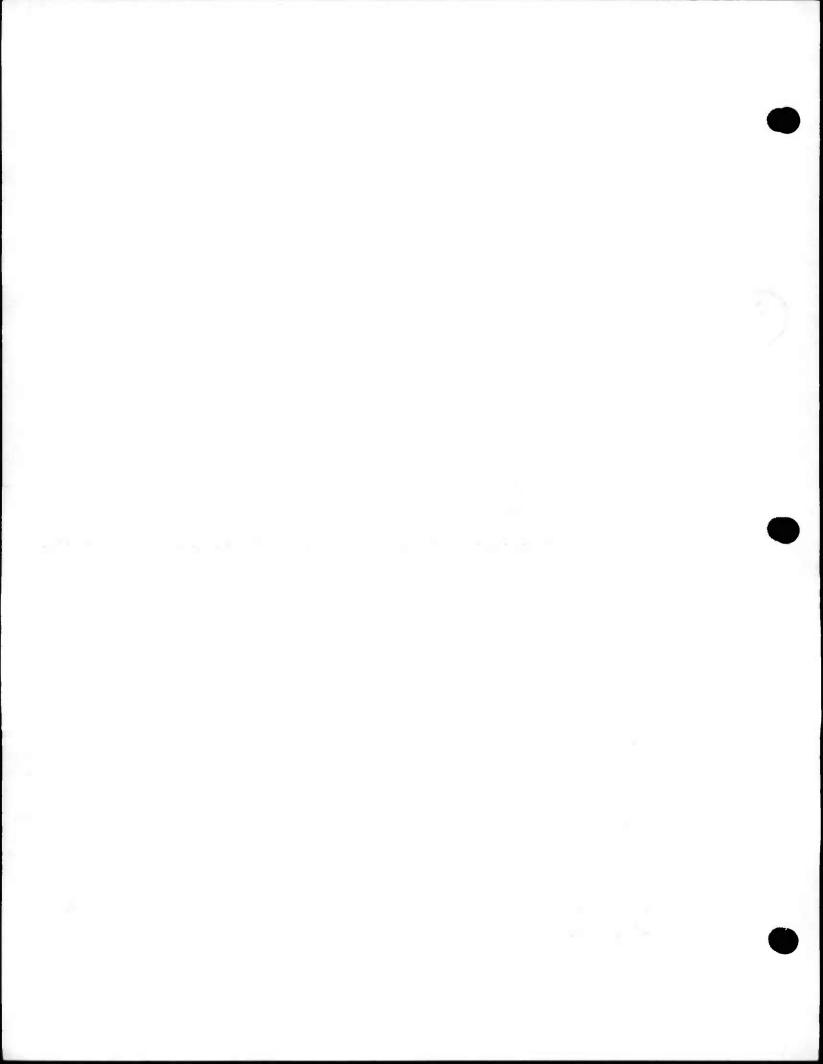
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital TO THE FLINERAL DIRECTOR. After this certificate has been signed by the artending physician and completely filled in by the funeral director, page 5 should be detached it be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA | L HYGIENE |
|--|-----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MAR | | | TMENT OF | | | NTAL HYGIEN | E | | | |
|------------------|--|------------------------------------|----------------------------|-------------|-------------------|-------------------|---------------|--|------------------|--|------------------------------|--|
| | 1. DECEDENT HE (First, Middle, Last) | J. | R | 17= | K, Sr | | | DATE OF DEATH | v _ 9 | YEAR 3. TIME OF | F DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. / | AGE (In yrs. lest | | IF UNDER 1 YE | | 24 HRS. 7. | DATE OF BIRTN | 6 | BIRTNPLACE (Ste | te or Foreign | |
| | 044-26-0688 | 1 M 2 D F | 55 | YRS. | MONTHS DAT | 8 HOURS | MIN. F | (Month, Day, Year) eb. 19, | 1935 | Country) Litchfie | eld. CT | |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, TOV | N OR LOCATIO | | | | Y OF DEATN | , | |
| 5 | Shady Grove Adve | ntist Hospi | tal | Rockville | | | | | | Montgomery | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| Ē | | rfax | | Great Falls | | | | | | 10d. INSIDE CITY LIMITS? 1 TYES 2 X NO | | |
| | 10e. STREET AND NUMBER | 11dx | | GI | eat ra | 101. ZIP CODE | F | | I too CITIZE | 1 U YES | _ | |
| FUNERAL DIRECTOR | 801 Lunenburg Ro | ad | | | | 2206 | | | U.S | | | |
| N N | 11. MARITAL STATUS | 12. WAS DECEDENT EV | ER IN U.S. ARI | MED | 13. WAS | | | ORIGIN? (Specify Yes | | 4. RACE — America | en Indien. | |
| E | 1 Never Married 2 Married | FORCES? 1 XX | YES 2 N | 0 | If yes | | n, Maxican, P | uarto Rican, atc.) | | Specify: White, atc | C. | |
| B₹ | 3 Widowed 4 Divorced | Korean | | | | | | | | , , , , , , , , , , , , , , , , , , , | LLE | |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad | UCATION le completed) | (GA | ve kind of | USUAL OCCUI | | ng | 186, KIND OF BUS | SINESS/INDU | STRY | | |
| ١٣ | Elementary/Secondary (0-12) | College (1-4 or 5+) | | Do NOT u | | | | D C T | _ | | | |
| × | 12. 17. FATNER'S NAME (First, Middle, Last) | 4 | Syst | ems | Engine | | HEDIC MANE | R.G.I. | | • | | |
| ၓ | Unknown | | | | | | | Blazek | Sumame) | | | |
| H | 19a. INFORMANT'S NAME (Type/Print) | | 196 | . MAILING | ADDRESS (Str | | | b Number, City or Tow | rn. State. Zip C | Code) | | |
| 임 | Constance L. Bla | zek | | | | | | eat Falls | | | | |
| 1 | 20a. METNOD OF DISPOSITION | - | | OF DISPO | SITION (Name o | | | | | ty or Town, State | | |
| | 1 Burial 2 Cremation 3 Res | — Suite | St. A | ntho | ny's C | emeter | У | Lit | chfie | 1d, CT | | |
| | 21. SIGNATURE FUNERAL SERVICE L | ICEMPEE / | / | | 22. NAM | E AND ADDRE | SS OF FACILI | 1 Home | | | | |
| ł | V. 1211 | Rley 1 | 2 M | w | 7 | | | reet, He | cndon | VA 2207 | 70 | |
| | 23. PARTA. Enter the diseases, or | complication that ca | used the da | ath. Do | | | | | | at, App | roximata | |
| | ahock, or haart fallure IMMEDIATE CAUSE (Final | . List only one cause | on aach lina. | | | | | | | | rvai Between et and Daath | |
| | disease or condition resulting in death) | METASE | ATIC L | E10 | MYOS | RCOK | IA OT | FILEW | 4 | 2 | YRS | |
| | | DUE TO (OR | AS A CONSEC | DUENCE C | F): | | | | | | | |
| Š | Sequentially list conditions, | b | AS A CONSEC | HENCE C | n· | | | | | | | |
| AT | If any, leading to immediate cause. Enter UNDERLYING | | | | , | | | | | į | | |
| 핕 | CAUSE (Disease or injury that initiated events | DUE TO (OR | AS A CONSEC | UENCE C | F): | | | | | | | |
| CERTIFICATION | reaulting in death) LAST | d | | | | | | | | | | |
| ū | PART ii. Other significant condition | one contributing to de | eth but not r | eauiting | in the under | ving cause | given in Pa | rt I. 24a, WAS AN | AUTOPSY | 24b. WERE AUT | OPSY FINDINGS | |
| CAL | | | | | | , | | PERFO | RMED? | AVAILABLE | PRIOR TO | |
| | | | | | | | | _ 1 TES 2 | NO NO | DF DEATH | ? 2 🗌 NO | |
| Σ. | | | | | | | | - | | '- 123 | 1 | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | - 2 | 8. PLACE OF D | DEATH (Check | only one) | · | .1 | | |
| Sic | 1 WES 2 NO | HOSPITAL: | R/Outpetlant 3 | □ DOA | OTHER: | Home 5 🗆 R | esidence 6 | Other (Specify) | | | | |
| PHYSICIAN: MEDI | 27. MANNER OF DEATN | 28a. DATE OF INJ (Month, Day,) | | 28b. TII | IE OF 280 JURY | . INJURY AT WORK? | 20 | Bd. DEŞCRIBE NOW | INJURY OCCU | JRED | | |
| B | Natural 5 Pending Investigation | | | | | YES 2 | | | | | | |
| | 3 Suicide 8 Could not be 4 Nomicide determined | 28s. PLACE OF IN building, etc. | IJURY — At ho (Specify) | ma, farm, | street, factory, | office | 28 | Bf. LOCATION (Street City or Town, State, | and Number o | or Rural Route Numb | er, | |
| E | | | | _ | | | | | | | | |
| MPL | cool | SICIAN: To the best of my | | | | | | | | | | |
| COMPLET | | NER: On the basis of exem | inition and/or i | Investigati | on, in my opini | | | | nd due to the | cause(a) and mani | ner se stated. | |
| BE | 290 SIGNATURE AND TITLE OF CERTIFI | R | MX | | | 29c. LIC | TO TO C | R | 29d. DATE | SIGNED (Month, De | sy, Ybar) | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | VHO-COMPLETED CAUSE | OF DEATH (ITE | M 27) (75m | a. Print) | 12 | ULLX | 1 | - () | 7117 | 2852 | |
| | Anso A | ROMUNI | MIN | 14 | 808 + | + Yeins | nose 1 | A415#7 | 12-P | VVVILLE | 101 | |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRARIS | SIGNATURE | | 404.1 | | G047 F | ANT " | 7- | resident | , ", | |
| | DEC 1 4 1990 | gruna Davi | doon-Ran | ndelle | | | | | | | | |
| | | | | | | | | | | | | |



inclina and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should thus to burial, cremation, or removal. traumatic event, the medical examiner must be notified at once. ute the executed within 2 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL DIRECTOR: After this certificate has been signed be filed within 72 hours after death with the State Dept. of Health IMPORTANT: If Item 28 is marked, or Item 23 shows any

| | FOR | STATE OF MARYL | AND / DEPART | MENT OF HEALTH AND | MENTAL HYGIE | NE (| 90 34220 |
|------------|--|--|--|--|---|--------------------------|--|
| | 1 - STATE REGISTRAR | | | CATE OF DEATH | REG. NO | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | Ryha | | | 2. DATE OF DEATH | DAY YE | 3. TIME OF DEATH |
| | 4, SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (| In yrs. lest birthdey) | IF UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign |
| | 260-321434 | 1 - M 2 V F | YRS. M | IONTHS DAYS HOURS MIN. | (Month, Day, Year) | 03 C | Country) |
| OR | e. FACILITY NAME (If not institution, give st | emeday | R. | Beltinor | EATH ' | 9c. COUNTY | OF DEATH |
| 5 | RESIDENCE OF DECEDENT | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | loc. City, | TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 3000 W Bo | Hechlo F | lve | 101. ZIP COOE 21215 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13. WAS DECENDENT OF HISPA | | ee or No- 14. | RACE — American Indian, Black, White, atc. |
| В | 1 Never Merried 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES | | If yes, specify Cuban, Mexico 1 ☐ YES 2 ☑ NO Specif | | | Specify: Black |
| 유 | 15. DECEDENT'S EDUC | | 18e. DECEDENT'S U | SUAL OCCUPATION | 18b. KIND OF B | USINESS/INDUST | TRY |
| COMPLETED | (Specify only highest grade Elementery/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT use | rk done during most of working retired.) | | | |
| ≥ | 17. FATHER'S NAME (First, Middle, Last) | | TONIA. | | AME (First, Middle, Maide | an Sumama) | |
| BE C(| HENRY NEWS | ON | | | THE (FROM MICHOLOGY MICHOLOGY | an damano) | |
| | 190, INFORMANT'S NAME (Type/Print) | | 19b. MAJLING A | DDRESS (Street and Number or Rural | Route Number, City or To | own, State, Zip Coo | de) |
| 유 | RUTH COLEMA | ~ | 39001 | J. BELVEDERE F | 10-726 BA | ATO. M. | 21215 |
| | 20e. METHOD OF DISPOSITION 1 Suriel 2 Cremetton 3 Remi | 206 | other placel | TION (Name of cametery, crematory or | 20c. 1 | OCATION - City | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENCEE | 17 X10 N | 22. NAME AND ADDRESS OF FA | I A | 72/0 | -0 / 10 |
| | 21. SIGNATURE OF POWERAL SERVICE LA | ENSEE | | JOSEPH L. RO | | | |
| | -heart he to | 7,100 | | 2222 W. No | OTO DO | Paren | Ma21211 |
| | 23. PART I. Enter the diseases, or o | omplications that caused | tha death. Do no | | | | |
| | | List only one cause on e | | / | | THE PERSON NAMED IN | Intarvai Batwean |
| | iMMEDIATE CAUSE (Finsi disesse or condition | | (40 . | 10 - | | | Onaet and Death |
| | resulting in death) | · Cai | v ce | Rectum | | | YAS |
| | | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | (|
| Z | Commence that commence | b | | | | | |
| TIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | C | | | | | |
| 涯 | that initiated events | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | |
| 1 | reaulting in death) LAST | d | | | | | |
| SO | | | | | | | , , |
| A | PART ii. Other algnificant condition | s contributing to death b | ut not resulting in | the underlying cause given in | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | Decibitus | ulcers | | | 1 _ YES | 2 NO | COMPLETION OF CAUSE OF DEATH? |
| ᇤ | | | | | | | 1 TYES 2 NO |
| ≥ | | | | | _ | | 10.2010 |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 00 PLACE OF 05 4TH (0 | h | | |
| ᅙ | EXAMINER? | HOPPITAL: | | 28. PLACE OF OEATH (C. | neck only one) | | |
| ΥS | 1 YES 2 TANO | 1 Inpatient 2 ER/Outp | | 4 - Nursing Home 5 - Reeldence | | | |
| PHYSI | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | IRY WORK? | 28d. DESCRIBE HOV | V INJURY OCCUP | REO |
| BY | 2 Accident Investigation | | | M 1 YES 2 NO | | | |
| ED | 3 Suicide 8 Could not be 4 Homicide datermined | 28e. PLACE OF INJURY building, etc. (Spec | cify) | reet, fectory, office | 28f. LOCATION (Stre- City or Town, Sta | et end Number or ite) | Rural Route Number, |
| <u> </u> | 290. CERTIFIER | CIAN. To the best of section | dida di da d | d and district and an arrangement of the second | | | |
| COMPLET | (Check only | | | d at the time, date end piece, end du | | | |
| 힍 | 2 MEDICAL EXAMINE | H: Of the basis of exemination | n end/or investigation | , in my opinion, death occured at th | e time, date and piece, | end due to the c | ause(a) and menner ee stated. |
| ш | 290. SIGNATUSE AND TUKE OF CENTIFIE | | | 29c. LICENSE NU | | 29d. DATE S | IGNED (Month, Day, Year) |
| B | 411 | napr | 10 Alt | 10/n D/2 | 1622 | 12 | 11/190 |
| | 30. HAME AND ADDRESS OF PERSON WI | O COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | Print) | | | |

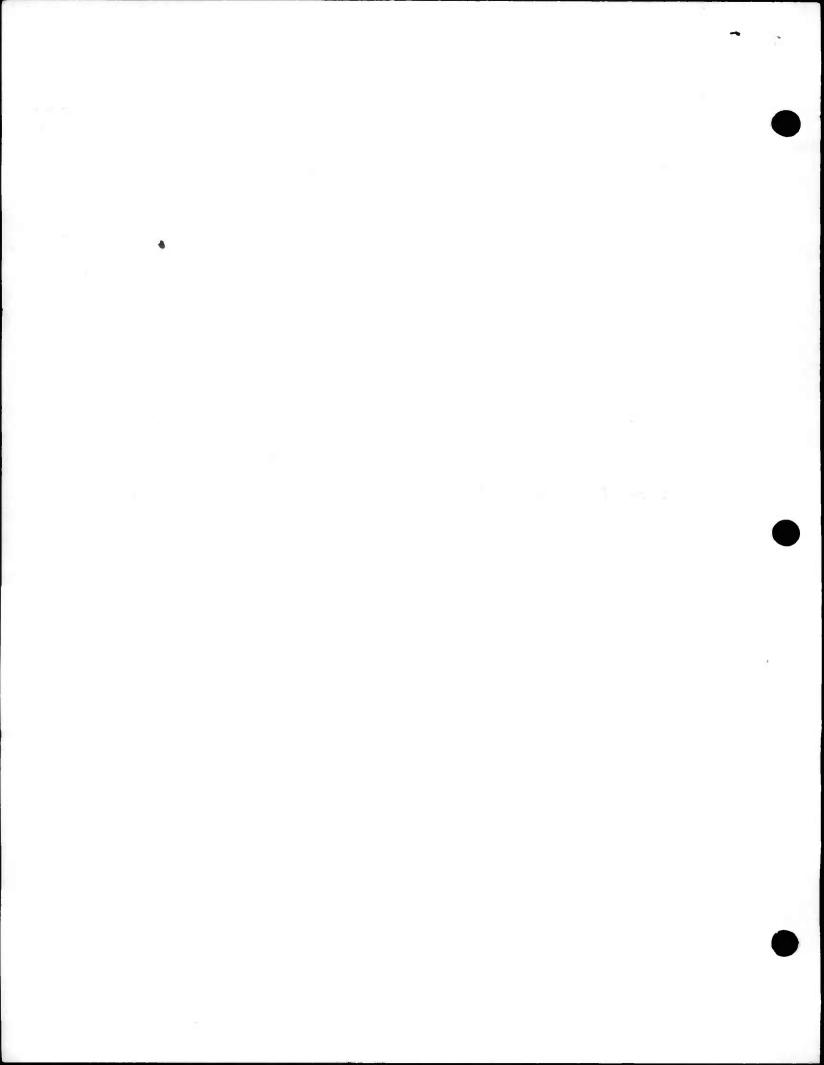
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Mental Hygiene prior to burial, cremation, or removal.

Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requirement TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. Or Health IMPORTANT: It item 28 is marked, or item 23 shown Imp

| | FOR 1 - STATE REGISTRAR | STATE OF MA | | | | | ALTH AND | MEN | ITAL HYGIENE | | 90 | 3422 |
|-----------------|--|--------------------------------|---------------------|-------------|--------------|--------------|---------------------|---------|--------------------------|---------------|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | DATE OF DEATH | | 3 | . TIME OF DEATH |
| | Elmer Eugene | Crudden | | | | | | | 12 12. | 90 | YEAR | 10.51 AG |
| | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. last | birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | | DATE OF BIRTH | 70 | 8. BIRTHPL | ACE (State or Foreign |
| | 217-05-7805 | 1 0 M 2 □ F | 78 | YRS. | MONTHS | DAYS | HOURS MIN. | (4 | Month, Day, Year) 2 6 12 | | Country) | rvland |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY | , TOWN OR | LOCATION OF | DEATH | | | NTY OF DEA | |
| ٣l | Baltimore Count | y General | Hospit | al | Ran | dalls | stown | | | | Balti | more |
| ธี | RESIDENCE OF DECEDENT | | - 100 | | | | | | | | | |
| DIRECTOR | Monara and Dar 1 | | | 10c. CIT | | OR LOCATIO | | | | | | Dd. INSIDE CITY LIMITS? |
| | Maryland Balt | imore | | | Pik | esvil | Lle ZIP CODE | | | | | YES 2 XNO |
| BY FUNERAL | | 1266 p 1 | | | | 107. 2 | | ^ | | 10g. CITI | ZEN OF WH | AI COUNTRY? |
| ᄬᅵ | 712 Templec | 12. WAS DECEDENT | EVED IN U.S. ADA | 4EO | 12 | WAS DECE | 2120 | | RIGIN? (Specify Yea | ar No. I | | .S.A. |
| ᆲ | 1 Never Married 2 Married | FORCES? 1 _ | YES 2 X N | | | If yes, spec | Ify Cuban, Maxic | an, Pu | | or No | | - American Indian, White, atc. |
| | 3 🔀 Widowed 4 🗌 Divorced | IF TES, GIVE WAR | OH DATES | | | I L TES 2 | NO Spec | ary: | | | Specify: | hite |
| | 15. DECEDENT'S EDI (Specify only highest grad | | 16a. DEC | CEDENT'S | USUAL O | CCUPATION | of constitue | | 18b. KIND OF BUS | INESS/INC | DUSTRY | |
| ᇤ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. | Do NOT us | se retired.) | during most | or working | | | | | |
| 릴 | High School | | | Pain | ter | | | | Self. | -Emp | loyed | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S N | AME (F | First, Middle, Maiden S | Surname) | | |
| BE | William Elm | ner Crudde | en | | | | Ma | ry | Buschman | | | |
| 0 | 19s. INFORMANT'S NAME (Type/Print) | • 1 | 19b | | | | | | Number, City or Town | | | |
| - | Mrs. Nancy I | iberto | | | | | liff R | | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burtal 2 □ Cremation 3 □ Ran | noval from State | other pla | ce) | | | etery, crematory or | | ì | | City or Town | |
| | 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | locklose) | Reist | erst | | | Ch. Cer | | | ster | stown | , MD |
| | 21. SIGNATURE OF FUNERAL SERVICE L | V | / - | 7 | [22. | Lorin | g Byers | s F | uneral D: | irec | tors, | Inc. |
| | Staphentil | Ford | A~ | | 8 | 728 L | iberty | Ro | ad Randa | 11st | own, l | MD 21133 |
| | 23. PART I. Enter the diseeses, or ahock, or heart failure | complications that | coused the de | sth. Do s | not enter | the mode | e of dying, eu | ch as | cerdiac Dr reepir | etory ari | rest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel | . Liet billy one ceds | | | | 0 | | | | | | Onaet end Death |
| | disease Dr condition resulting in deeth) | · INTE | CKOP | 071 | E | KIO. | R M | 1 | | | | OMIN |
| | 0000 10 J 00 3-40-4 | DUE TO (O | R AS A CONSEC | | | | | | | | | |
| Ζl | Sequentially ilst conditions, | b | | | | | | | | | | |
| CERTIFICATION | if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (C | R AS A CONSEC | UENCE O | F): | | | | | | | |
| 윤 | CAUSE (Disease or Injury | c. DUE TO (C | R AS A CONSEC | UENCE O | Ð: | | | | | | | <u> </u> |
| | that initiated events resulting in deeth) LAST | | | | | | | | | | | |
| 빙 | | a | | | | | | | | | | |
| B | PART II. Other algnificant condition | | | | in the u | nderiying | cauae given i | n Peri | I. 24e. WAS AN PERFOR | | _ A | VERE AUTOPSY FINDINGS WAILABLE PRIOR TO |
| 음 | Copp | DEM | ENTI | A | | | | | 1 - YES 2 | □ NO | | OMPLETION OF CAUSE OF DEATH? |
| 뿔 | | | | | | | | | | | 1 | YES 2 NO |
| z l | | | | | | | | | | | | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | CE OF DEATH (C | Check o | nnly one) | | | |
| YS | 1 TYES 2 NO | 1 Inpatient 2 I | | | 4 🗆 Nui | rsing Home | 5 - Residence | _ | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF IN (Month, Day | | 28b. TIM | JURY M | 28c. INJU | IK? | 280 | d. DESCRIBE HOW IN | IJURY OC | CURED | |
| BY | 2 Accident Investigation | 280 BLACE OF | INJURY — At ho | - form | | | S 2 NO | 200 | . LOCATION (Street a | and Alicanter | a as Orient Day | uto Alicentes |
| 유 | 3 Suicide 6 Could not be 4 Homicide detarmined | building, at | c. (Specify) | nse, rairm, | street, rac | nory, office | | 201 | City or Town, State) | na Number | r or nural not | ote Number, |
| ᆸ | 29a. CERTIFIER | | | | _ | _ | | | | | | |
| <u> </u> | (Check only | SICIAN: To the beat of m | | | | | | | | | | |
| COMPLETED | | IER: On the besis of exs | minution and/or i | mesngan | on, in my | | | | | | | |
| BE | 296. SIGNATURE AND TITLE OF GERTIFI | ER . | 2 | | | | 29c. LICENSE N | UMBER | 777 | | | Wonth, Day, Year) |
| 2 | 20 NAME AND ADDRESS OF STREET | W COU | / | 4.07. ~ | 0.4 | | V L | (- | رد، | | 2.12 | . 10 |
| | 30. NAME AND ADDRESS OF PERSON W | M D | C C. U | w 27) (Type | Print) | DAT | LSTON | N | . Mr |) 31 | 133 | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | 'S SIGNATURE | - | 71.0 | 7.10 | - / / 01 | | 1 1 50 | ~ | 127 | |
| - 1 | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | Acha Davido | - Aanda | JSL. | | | | | | | | |
| I | DEC 1 4 1990 | / Language | | | | | | | | | | |

DHMH-16 Rev 1/69



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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death commitments of within 24-mours after death. Page 6 may be retained by the hospital properties. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attenting acceptance completely filled in by the funeral director, page 5 should be detache | be filed v | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or when transmitteevent, the medical examiner must be notified at once. | |

31. DATE FILED (Month, Day, Year)
DEC 14 1990

32. REGISTRAR'S SIGNATURE
Davidson-Randall

| • | FOR STATE REGISTRAR | | STATE OF MAR | | DEPAR | | | | | MENT | TAL HYGIENE REG. NO. | | 90 | 34222 | |
|--------------|---|--|---|-----------------------|---------------|---|----------------|------------------|------------|-----------------------|--|-----------------|--|---|--|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | Cok | ER | | | - | | | 2. OA | TE OF DEATH | | 90 | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER 561-09-2 | | | AGE (In yrs. las | YRS. | IF UNDER | 1 YEAR DAYS | IF UNDES | MIN. | 7. DA | TE OF BIRTH onth, Day, Year) | | 6. BIRTI Count | HPLACE (State or Foreign ny) Ohio | |
| DIRECTOR | Deaton F | tosp. 1 | treet and number) Nedical Ca | nter | , | | 1 | | Cit | | | 9c. COU | INTY OF D | DEATH | |
| ֝֟֝֟֝֟֝֟֝ | RESIDENCE OF DEC | 10b. COUNTY | Y | | 10c. CIT | c. CITY, TOWN OR LOCATION | | | | | | | | 10d. INSIDE CITY | |
| Ĕ | Maryland | Bal | ltimore | | Į į | Woodlawn | | | | | | | | 1 TES 2 NO | |
| į | 10e. STREET AND NUMBER | | | _ | | | _ | , ZIP COO | E | | | 10g. CIT | ZEN OF | WHAT COUNTRY? | |
| | 6811 Campfi | leld Ro | oad | | | | | 21 | 207 | | | U. | S.A | | |
| LOINER | 11. MARITAL STATUS | | 12. WAS DECEDENT EX | ER IN U.S. AF | MED | 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Year or No. 14. R. | | | | | | 14. RAC Blac | E — American Indian, k, White, atc. | | |
| | 1 Never Married 2 3 Never Married 2 3 Never Married 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 | | IF YES, GIVE WAR | | | | | | Specif | | ,, | | Spec | | |
| | | EDENT'S EDU | CATION | 140.05 | CEOENT'S | LISUAL O | CCUBATI | DM . | | | 16b. KIND OF BUS | INECC/IN | DUSTRY | - U.D.A. | |
| COMPLEIED | (Specify onl | ly highest grade | completed) | (G | ive kind of a | work done se retired.) | during mo | st of worki | ing | | 100. KIND OF BUS | INC 35/IN | DUSTRI | | |
| 2 | Elamentary/Secondary (I | 0-12) | Collage (1-4 or 5+) | Fi | re Un | derw | rite | er | | | Insur | ance | 2 | | |
| 5 | 17. FATHER'S NAME (First, M | fiddle, Last) | | | | | | · · · · · · | HER'S NA | ME (Fir | st, Middle, Meiden | | | | |
| | William Fan | gmeyer | • | | | | | I | la | | | | | | |
| 0 0 0 | 19a, INFORMANT'S NAME (| | | 19 | b. MAILING | ADDRES | S (Street | and Numbe | r or Rural | Route N | lumber, City or Town | , Stete, Zi | ip Code) | | |
| ۱ ۲ | Augsburg Lu | theran | Home | | 6811 | Cam | pfie | eld E | Road | nd Woodlawn, MD 21207 | | | | | |
| ĺ | 20a. METHOD OF DISPOSIT | | oval from State | 20b. PLACE other p | lace) | | | | | | 20c. LO | CATION - | - City or T | own, Stata | |
| | 4 Donation 5 Othac | r (Specify) | | | Par | kwoo | | | | | | kvi] | lle, | Maryland | |
| | 21. SIGNATURE OF FUNERA | A | CENSEE | | | 8 | 728 | ND ADDRE Libe | ess of FA | Roa | ad Rand | a11s | stown | . MD 21133 | |
| | > John | John K Agring Loring | | | | | | | | | | | | | |
| | 23. PART I. Enter the d | | complications that ca List only ons causs | | | not snts | r tha mo | da of dy | ing, suc | h ss c | cardisc or respi | ratory a | rrest, | Approximats interval Between | |
| | IMMEDIATE CAUSE (FI | | 1 - | on each int | 1 | ter Carlo Vanle Disea | | | | | | Onsst and Dasth | | | |
| | disease or condition resulting in death) | \rightarrow | a. Men | ascl | end | les Cardo Vasula ! | | | | | le ble | Isean yea | | | |
| | | | DHE TO (OF | AS A CONSE | QUENCE O | DF): + 1 + | | | | | 9 | | | 10 2 | |
| S | Sequantially ilst condi- | tions, | b. //www | AS A CONSE | OUENCE O | ac 1 | 7 | 1 1 | fe | e | ~ | | | 100% | |
| T | if any, lasding to imme cause. Enter UNDERLY | | Date | e B | Joence 9 | ne | le | iti | 6 | | | | | nen | |
| RTIFICATION | CAUSE (Disesse or injuted that initiated svents | ury | DUE TO (OR | AS A CONSE | QUENCE O | OF): | | | | | | | | | |
| Ē | resulting in death) LAS | ST | d. | | | | | | | | | | | 3 | |
| E | PART IL Other signific | ant condition | ne contributing to do | eth but not | regulting | In the su | nderivia | a cause | elven in | Don't I | i. 24a, WAS AN | ALITOREY | | b. WERE AUTOPSY FINDINGS | |
| 8 | 1000 | li- | | Con | | | nuanyin | y cause | givan in | raiti | PERFOR | | - | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDIC | Danie | 21.6 | em | 0 | | | | | | | 1 _ YES 2 | .NO | | OF DEATH? | |
| Σ | Hura | 1 VES 2 NO | | | | | | | | 1 YES 2 NO | | | | | |
| Z | 25. WAS CASE REFERRED | TO MEDICAL 28. PLACE OF OEATH (Check only one) | | | | | | | | | | | | | |
| Y PHYSICIAN: | EXAMINER? | HOSPITAL: OTHER: 1 □ Inpetient 2 □ ER/Outpetiant 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) | | | | | | | | | | | | | |
| | 27. MANNER OF DEATH | | 28a. DATE OF IN. (Month, Day, | IURY Year) | 28b. TIR | | 28c. IN | JURY AT | | 7 | DESCRIBE HOW I | NJURY O | CCURED | | |
| | 1 Netural 5 2 Accident | Pending Investigation | , | , | | М | | YES 2 | □ NO | | | | | | |
| ED | a D autota | Could not be determined | 26e. PLACE OF If building, atc | | oma, farm, | atreet, fac | ctory, offi | Ce C | | | LOCATION (Street a Cify or Town, State) | and Numb | er or Rural | Route Number, | |
| _ " | 29a. CERTIFIER | TIEVING BUILD | DICIANI To the best of | Internal of the Co | l- oth | | | | | . 62 *** | | | | | |
| COMPLE | (Check only | | SICIAN: To the best of my ER: On the bests of exam | | | | | | | | | | | (a) and manner as atsted. | |
| | 29b. SIGNATURE AND TITL | | | | | .,, | | | CENSE NU | | F. F. F. F. F. F. F. F. F. F. F. F. F. F | | | D (Month, Day, Year) | |
| 8 | Kilan | No 1 | Hoca | O W | M | | | 1) | O / | 86 | 0 | ≥ / | L_ | 12-52) | |
| 2 | 30 NAME AND ADDRESS C | OF PERSON/WI | HO COMPLETEO CAUSE | OF DEATH (ITI | EM 27) (Typ) | e, Print) | 1 - | | | , | 611 | 5.0 | c.h. | 11654 | |
| - 1 | 1102TOV | 1 410 | SUITAL | -NB | 20d | 100 | 16 | On | 10 | 1 | 1 1-11 | Z ` _ | 1 | 1/277 | |

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DHMH-18 Rev 1/89

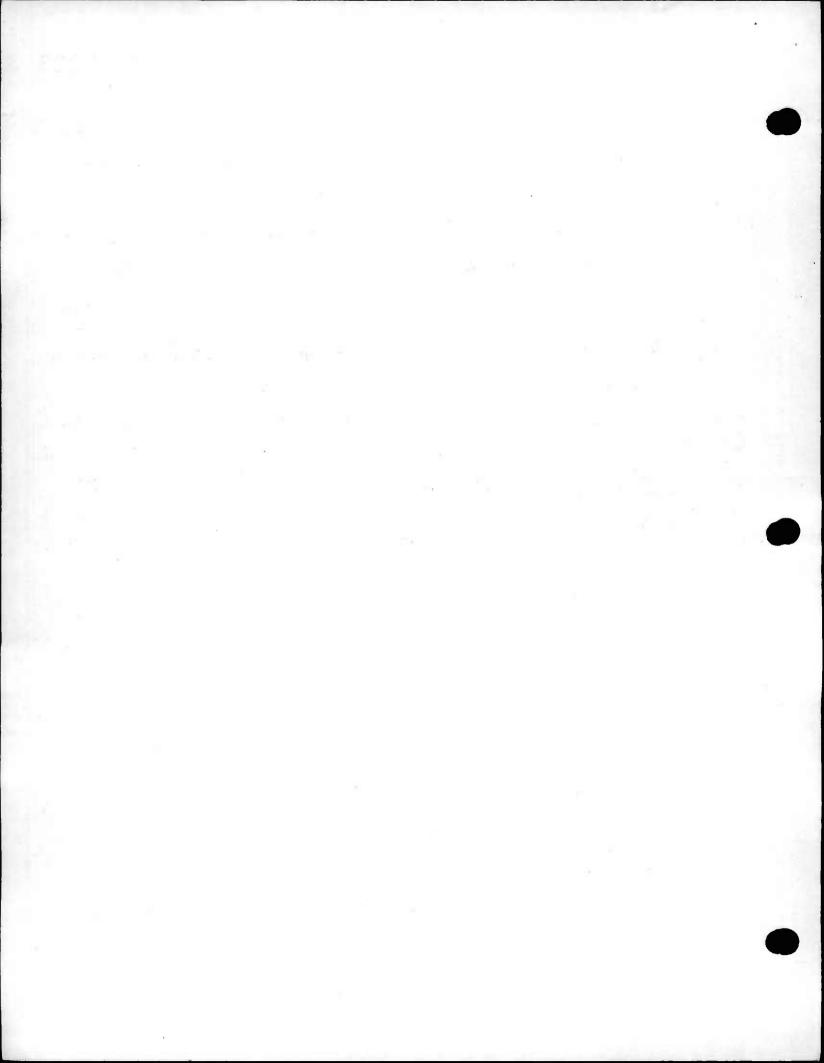
The attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit mental Hygiene prior to burial, cremation, or removal. ours after death. Page 6 may be retained by the hospital or attending physician. death certificate be executed within

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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| | . 2, 3 | |
| | Pages 1 | |
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FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | CERTIF | CATE OF | DEATH | REG | NO. | | | | | |
|------------------|---|---------------------------------------|--------------------------------------|---|---|------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEA | гн | 3. TIME OF DEATH | | | | |
| | Paul Ervin Cooke | | | | 12 - | L4 90 | YEAR 0645 M | | | | |
| A CASSESSION | 4. SOCIAL SECURITY HUMBER 5. SEX 6. 123-32-4657 | . AGE (In yrs. last birthday) 65 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRT (Month, Day, Ye 10 22 | н | 6. BIRTHPLACE (State or Foreign Country) Maryland | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN O | R LOCATION OF DE | | | TY OF DEATH | | | | |
| TOR | Baltimore County General | Hospital | Randa1 | 1stown | | Bal | timore | | | | |
| IREC | Maryland Baltimore | | r, TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO | | | | |
| 7 | 10e. STREET AHD NUMBER | | Baltimor | ZIP CODE | | 100 CITIZ | EH OF WHAT COUNTRY? | | | | |
| FUNERAL DIRECTOR | 8309 Mindale Circle Ap | | | 21207 | | | U.S.A. | | | | |
| BY FU | 11. MARITAL STATUS 1 Never Married 2 Married 12. WAS DECEDENT FORCES? 1 2 | YES 2 HO | If yes, spe | EHDENT OF HISPAN Holly Cuban, Mexical 2 X NO Specify | n, Puarto Rican, at | ly Yes or Ho— 1 c.) | 14. RACE — American Indian, Black, White, atc. Specify: | | | | |
| ED | 15. DECEDENT'S EDUCATION | | USUAL OCCUPATIO | NA | 185 KIND C | F BUSINESS/IHDU | White | | | | |
| COMPLETE | (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) | (Give kind of v | vork done during mos re retired.) | st of working | | | | | | | |
| MP | 12 Years | Charter | r Bus Dr | | | | ach Tours | | | | |
| 8 | 17. FATHER'S HAME (First, Middle, Last) | | | | ME (First, Middle, M | , | | | | | |
| BE | Ervin A. Kummer | | | Dais | ey Emma | Kehlin | g | | | | |
| 70 | 19a. IHFORMAHT'S HAME (Type/Print) | | | nd Number or Rural F | | | · / | | | | |
| - | Mrs. Grace E. Cooke | 8309 | Mindale | Circle A | Apt. B | Baltimo | re, MD 21207 | | | | |
| | 20s. METHOD OF DISPOSITION 1 (Surial 2 Coremation 3 Removal from State 4 Donation 5 Other (Specify) | 20b. PLACE OF DISPOS other place) | | netery, crematory or on Servi | | U amp at | ead, Maryland | | | | |
| | 21. SIGHATURE OF FUHERAL SERVICE LICENSEE | Garrorr | 22. NAME AN | D ADDRESS OF FA | CILITY | | | | | | |
| | StephenMC | Jenkins | | | | | ors, Inc. | | | | |
| | 23. PART i. Enter the diseases, or complications that d | aueed the deeth. Do n | ot enter the mo | de of dving, suci | h as cerdiec or | respiratory arre | est, Approximate | | | | |
| | shock, or heert failure. Liet only one ceuse on each line. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) BUE TO (OR AS A CONSEQUENCE OF): Interval Between Onset end Deeth O' A) A | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A COHSEQUENCE OF): DUE TO (OR AS A COHSEQUENCE OF): | | | | | | | | | | |
| 0 | PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | |
| EDICAL | | PI | ERFORMED? | 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | |
| Σ | | | | | | | 1 TYES 2 NO | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 105 05 05 15 10 10 10 10 10 10 10 10 10 10 10 10 10 | | | 1 | | | | |
| PHYSICIAN: M | EXAMIHER? HOSPITAL: | | OTHER: | ACE OF DEATH (Ch | eck only one) | | | | | | |
| YS | | R/Outpetlant 3 DOA | | e 5 🗆 Residence | | | | | | | |
| ВУ РН | 27. MANHER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | JURY 285. TIM Year) INJ | URY WO | URY AT RK? /ES 2 NO | 26d. DESCRIBE | HOW INJURY OCCI | URED | | | | |
| | | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of m 2 MEDICAL EXAMINER: On the basis of axar | | | | | | | | | | |
| | 29b. SIGNATURE AND JUTLE OF CERTIFIER | | | 29c. LICENSE HUN | MED | 294 DATE | SIGNED (Month, Day, Year) | | | | |
| TO BE | C. Mari Miss | | | D: | 3733 | 3 1 | 2.14.90 | | | | |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE C. R. AVI M. B. | OF DEATH (ITEM 27) (Type, | VOALC | STOW | NMI | 2113 | 3.7 | | | | |
| | 31. DATE FILED (Month, Day, Year) 32. REGISTRAR | | | | | | | | | | |

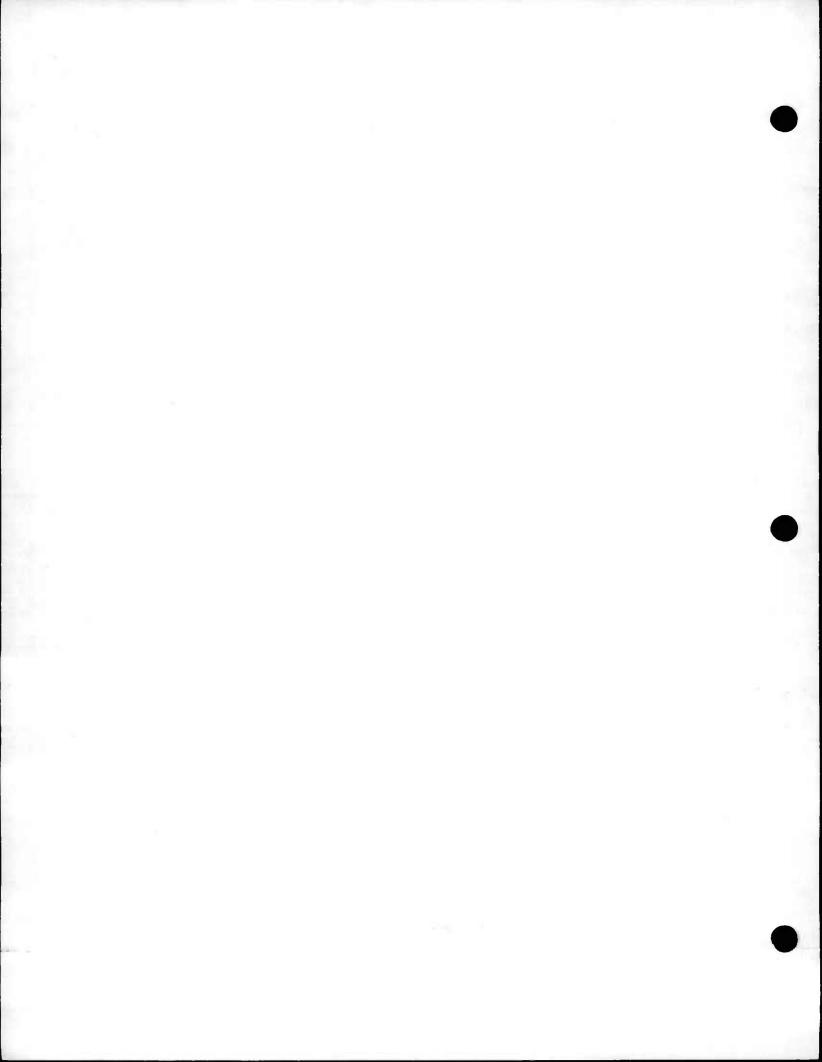


DIVISION OF VITAL

And the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should main and Mental Hygiene prior to burial, cremation, or removal. TO BE COMPLETED BY FUNERAL DIRECTOR that the death certificate be executed within 2. Yours after death. Page 6 may be retained by the hospital or attending physician. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION TO THE HOSPITAL DR ATTENDING PHYSICIAN TO THE FUNERAL DIRECTOR; After this certifical has been be filed within 72 hours after death with the Shark mouth.

| STATE OF | MARYLAND | / DEPARTMENT | 0F | HEALTH | AND | MENTAL | HYGIENE |
|----------|----------|--------------|----|--------|-----|--------|----------|
| | C | ERTIFICATE | 0 | F DEAT | TH | | REG. NO. |

| 1 - STATE REGISTRAR | STATE OF MARYLA | | TOF HEALTH AND | MENTAL HYGIENI REG. NO. | | • |
|--|--|---|---|---|--------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last | maria | 170 | 1.14 | 2. DATE OF DEATH | YEA | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In | yrs. last birthday) IF UNC | ER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 90 | RTHPLACE (State of Foreign |
| 216-52-8673 | 1 □ M 2 XF 3 | 9 YRS. MONTH | | (Month, Day, Year) 8 - 20- | | puntry) Md |
| 9e. FACILITY NAME (If not institution, give | street and number) | | TY, TOWN OR LOCATION OF D | EATH | 9c. COUNTY C | 4 |
| RESIDENCE OF DECEDENT | | | BALTO | | BAL | 010 0114 |
| 10e, STATE 10b, COUN | тү | 10c. CITY, TOWN | OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER | | Nu | 10f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 5310 Cec | il the | | 212 | | 4 | ·5A |
| 11. MARITAL STATUS 1 Never Merried | 12. WAS DECEDENT EVER IN U FORCES? 1 1 YES IF YES, GIVE WAR OR DAT | 2 NO | 3. WAS DECENDENT OF HISPAI If yes, specify Cuben, Mexico 1 YES 2 NO Specifi | n, Puerto Rican, atc.) | | ACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S ED | | 16a. DECEOENT'S USUAL | | 16b. KINO OF BUS | I INESS/INDUSTF | ny . |
| (Specify only highest grade) Elementery/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT use retired | ne during most of working f.) | MA | le dica | l Lab |
| 17. FATHER'S NAME (First, Middle, Last) | N | | 18. MOTHER'S NA | AME (First, Middle, Maiden | | c rac |
| George | Hnnis | | Hild | a Jora | dan | |
| 19a INFORMANT'S NAME (Type/Print) | raine. | 19b. MAILING ADDRI | SS (Street and Number or Rural | Route Number, City or Town | State, Zip Code | 21207 |
| 20e. METHOD OF DISPOSITION 1. Burlet 2 Cremation 3 Re | 20b. I | PLACE OF OISPOSITION other place) / A) | (Name of cemetery, cremetory or | 200.10 | CATION - City | |
| 4 Donation 5 Other (Specify) | | 1000 | dlaws Cen | etery B | 2/1/2, | Ma |
| San San | 12 Call | _ / | 2, NAME AND ADDRESS OF FA | H. West | chach | Ave |
| 23. PART I. Enter the diseases of | r complications that caused to List only one cause on each | the death. Do not and | er the mode of dying, suc | ch es cerdiec or reepi | retory srreet, | Approximete interval Batween |
| iMMEDIATE CAUSE (Final disease or condition | | | | | | Onset end Dseth |
| resulting in death) | S. JNTRA | CRANIAL | RIEED | | | |
| Constraints that any distance | L INCREI | ASED 1 | NTRA CRANI | AL Press | URE | 6 DAYS |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | 41 | CONSEQUENCE OF): | | | | |
| CAUSE (Disease or injury that initiated events | | Lensimo | | | | |
| resulting in death) LAST | d | | | | | |
| PART II. Other significant condition | ons contributing to death bu | t not resulting in the | underlying cause given in | Part i. 24a. WAS AN | | 24b. WERE AUTOPSY FINOINGS |
| | | | | PERFOR | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | 1 TES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF DEATH (C | beck only one) | 1 | |
| EXAMINER? | HOSPITAL: | tient 3 DOA 4 D | | | | |
| 27. MANNER OF DEATH | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? | 28d. OEŞCRIBE HOW I | NJURY OCCURE | D |
| 1 Natural 5 Pending trivestigation | 12/5/90 | 439 M | 1 YES 2 NO | und | mow | n |
| 3 Suicide 6 Could not b | building, etc. (Specifi | / | | 28f. LOCATION (Street City or Town, State) | | |
| 29a. CERTIFIER | | mmou | | 131 | | more at |
| (Check only | YSICIAN: To the best of my knowle INER: On the beste of examination | | | | | use(e) end manner ee stated. |
| 29b. SIGNATURE AND TITLE OF CERTIF | ER / | | 29c. LICENSE NU | MBER | 29d. OATE Sto | NED (Montje, Day, Year) |
| 1)4 | uglas in He | uson pe | D 100 | 72 | 121 | 11/90. |
| DOUGHS M. C | tenson. M | TH (ITEM 27) (Type, Print) | .22-5.6 | neen ST | \$ | ALT |
| | AZ REGISTRAR'S SIGNA | | | | | P. C. C. C. C. C. C. C. C. C. C. C. C. C. |



ages 1, 2, 3 should

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29b. SIGNATURE AND TITLE OF CERTIFIER

10 -

1990

tonn

31. DATE FILED (Month, Day, Year)

4

| mending physician. | funeral director, page 5 should be detached for use as the burial-transit permit. I | |
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| retained by the nospital or atten- | 5 should be detached for us | notified at once. |
| rs after death. Page 6 may be re | he funeral director, page | emoval. dical examiner must be notified at once. |
| WITH STEEL STEEL | and complete Titled in by the fune | event; he medical e |
| ath certificate be execut | g physician | ental regiens prior to been any, or other traumatic |
| IN: The law requires that the death certific | gned by th | |
| DING PHYSICIAN: The la | CTOR: After this certificate has | s after death with the State Dept. of Hearn and 128 is marked, or item 23 shows any in |
| | | |

FOR STATE REGISTRAR 34225 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEOENT'S NAME (First, Middle, Last)ALICE C. CAWOOD 2. DATE OF OEATH 2/9/90 YEAR 3. TIME OF OEATH W000 DECEMBER 9 1990 2:20 5. SEX 6. AGE (In vrs. last birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) MAY 22,1896 8. BIRTHPLACE (State or Foreign 4. SOCIAL SECURITY NUMBER DAYS HOURS 1 🗌 M 2 💢 F ALABAMA 94 400-09-4701 YRS. 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR COLUMBIA HOWARD HOWARD COUNTY GENERAL HOSPITAL RESIDENCE OF DECEDENT 10a STATE 10h COUNTY 10c. CITY. TOWN OR LOCATION 10d. INSIDE CITY COLUMBIA 1 YES 2 X NO HOWARD MARYLAND FUNERAL 10e STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 21045 5718 OLD BUGGY COURT 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 1 Never Married 2 Marrie 1 TYES 2 NO Specify: Specify: B 3X Widowed 4 Divorced BLACK COMPLETED 16e. OECEOENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) BEAUTICIAN COSMETOLOGY 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) SELINA SHAFFER DIXIE DIXON BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 JAMES COLEMAN (SON) 5718 OLD BUGGY COURT, COLUMBIA, MARYLAND 21045 20a, METHOD OF DISPOSITION
1X Burial 2 Cremation 3 Res 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State MARYLAND NATIONAL MEMORIAL PARK LAUREL, MARYLAND Donation 6 - Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1915 5555 TWIN KNOLLS ROAD, COLUMBIA, MD. 21045 Entar tha disease, or complications that daused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23. PART I. Entar tha disea Approximata Intervei Batwe **IMMEDIATE CAUSE (Final** Onset and Death disease or condition ailus Renal resulting in daath) DUE TO (OR AS A CONSEQUENCE OF): Laulus sonal LIMIL PHYSICIAN: MEDICAL CERTIFICATION Sequantially list conditions, if any, lasting to immediate DUE TO (OR AS A CONSEQUENCE OF): cause, Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 THO etient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27 MANNER OF GEATH 28a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF 28c. INJURY AT 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ 2 Accident 28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify) 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be ED 4 Homicide COMPLET 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as atated. (Check only one)

4552 12-2 9.90 ANO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1/01/4 MUSIOYS alumbia. 2 Knoll STIVE 32. REGISTRAR'S SIGNATURE Sandon-Randall

29c. LICENSE NUMBER

2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29d. DATE SIGNED (Month, Day, Year)

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BALTIMORE, MARYLAND

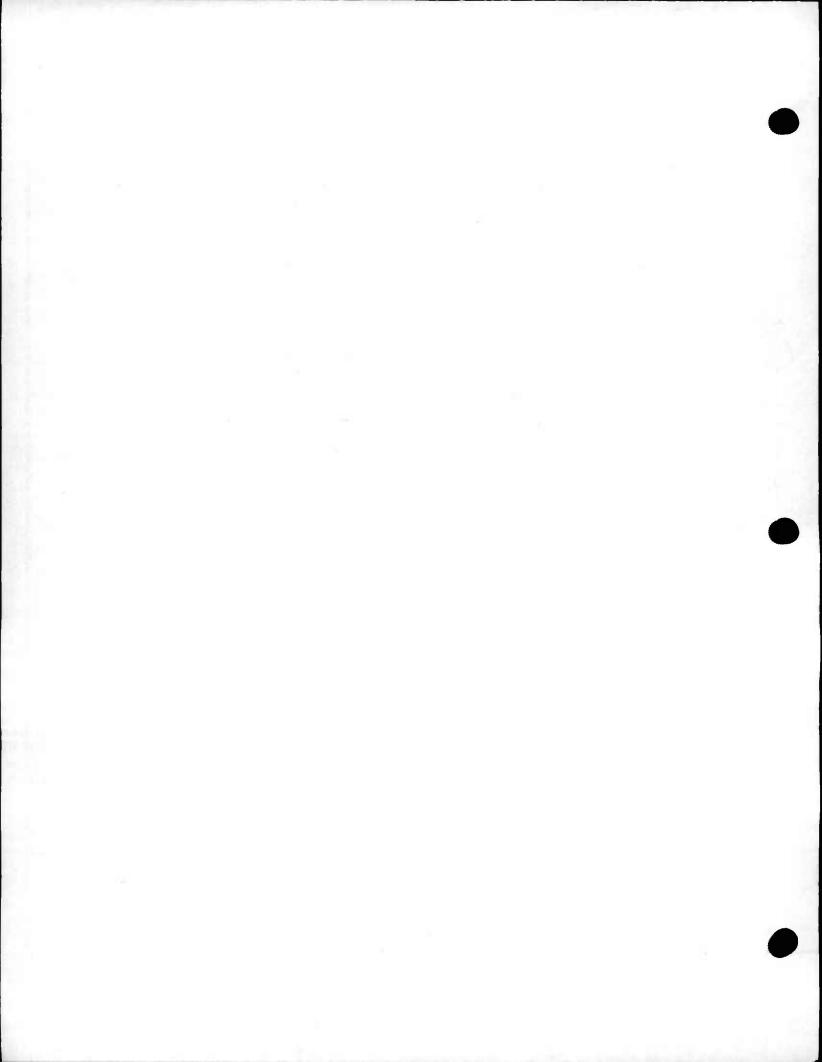
TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within c.v., Jours after death. Pag. 6 may be nationed by the distribution of the completely filled in by the funeral director, page 5 should be the distribution of the d

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 1 - FOR STATE OF REGISTRAR | | TMENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | | | |
|--|-------------------------------------|--|---|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 3 | . TIME OF DEATH | |
| Eugene | Leslie | Copeland Sr. | 12-12-9 | O YEAR | 4:50PM M | |
| 4. SOCIAL SECURITY NUMBER 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | 7. DATE DF BIRTH (Month, Day, Year) | 6. BIRTHPLACE (State or Foreign Country) | | |
| 215-40-5413 1 🗮 🛣 2 🗆 F | .1. | 9b. CITY, TOWN OR LOCATION OF DE | 5-12-41 | c. COUNTY DF DEA | 4D | |
| Pa. FACILITY NAME (If not institution, give street and number) Davis Motel-8312 Pulask: | i Hgwy. | Baltimore Cou | | | e County | |
| RESIDENCE OF DECEDENT | · • · · · · | | | | | |
| MD 10a. STATE 10b. COUNTY | 10c. CIT | Y, TOWN OR LOCATION BALTIMORE CIT | rv | | Od. INSIDE CITY LIMITS? YES 2 NO | |
| 10e. STREET AND NUMBER | | 101. ZIP COOE | | Og. CITIZEN DF WH | | |
| 1607 RICKENBACKER F | COAD | 21221 | | USA | | |
| 11. MARITAL STATUS 12, WAS DECED | ENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAI | | | - American Indian, White, atc. | |
| | 1 YES 2-ND WAR OR DATES | If yes, specify Cuban, Mexica 1 ☐ YES ★ NO Specify | | Specify: | | |
| 15, DECEDENT'S EDUCATION | 16a. DECEDENT'S | USUAL OCCUPATION | 16b. KIND OF BUSIN | ESS/INDUSTRY | DIGER | |
| (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or | (Give kind of a life. Do NOT us | work done during most of working se retired.) | | | | |
| | Coasta | al Manufactor: | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | ME (First, Middle, Malden Su | | | |
| Leslie E. Copeland 19a, INFORMANT'S NAME (Type/Print) | I an man min | Marce: AODRESS (Street and Number or Rural | | Morton | <u> </u> | |
| Sylvia Cooper | | Northrop Lane | | | 21220 | |
| 200 METHOD OF DISPOSITION | 20b. PLACE OF DISPOS | SITION (Name of cometery, crematory or | | FION — City or Town | | |
| 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Holly H: | ills Cemetery | Cha | se, | Md. | |
| 21, SIGNATURE OF FUNERAL SERVICE LICENSEE | 0 | 22. NAME AND ADDRESS DF FA | CILITY | | | |
| - Mongan Coag | | Wm.C. March | F.H. 1101 | E. No. | rth Ave | |
| 23. PART I. Enter the diseases, or complications shock, or heart fellure. List only one disease or condition Art. | cause on each lina. | not enter the mode of dying, suc cardiovascular | | tory errest, | Approximeta interval Batween Onsat end Death | |
| resulting in castn) | TO (OR AS A CONSEDUENCE O | | | | | |
| Sequentielly list conditions, b. | | | | | | |
| If any, leading to immediate cause. Enter UNDERLYING | TO (DR AS A CONSEDUENCE D | F): | | | j | |
| CALISE (Disease or injury | TO (OR AS A CONSEQUENCE O | F): | | | | |
| resulting in death) LAST | | | | | | |
| PART II. Other significant conditions contributing | to death but not resulting | in the underlying cause given in | Part I. 24s, WAS AN AL | TTOPSY 24b. 1 | WERE AUTOPSY FINDINGS | |
| Cirrhosis of liver du | | | PERFORM NYES 2 | 2.400 | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | | | AZ 123 2 [| - 1 | OF DEATH? Ú∑KYES 2 □ ND | |
| | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | 26. PLACE OF DEATH (C | heck only one) | | | |
| I III III III III III III III III III | 2 ER/Outpatient 3 DOA | OTHER: 4 Nursing Home Nursing Home | 6 Other (Specify) | | | |
| Natural 5 Pending (Mont | OF INJURY h, Day, Year) 28b. TIN | ME DF 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HDW INJ | URY OCCURED | | |
| | E OF INJURY — At home, farm, | | 281. LOCATION (Street and City or Town, State) | d Number or Rural Ro | oute Number, | |
| 4 Homicide detarmined | ing, etc. (Specify) | | City of rown, State) | | | |
| 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat | t of my knowledge, death occur | red at the time, data and place, and du | a to the cause(a) and menn | er as stated. | | |
| one) XXX MEDICAL EXAMINER: On the basis | of axamination and/or investigati | ion, in my opinion, death occured at the | e time, date and place, and | dua to the cause(a) | and menner as stated. | |
| AL HIGHATURE AND TITLE OF CERTIFIED CALL |) | 29c. LICENSE M | MBER | DATE SIGNED | (Month, Day, Year) 3–90 | |
| | TALLES OF DEATH STEM 120 CEM | | | | | |
| MARGARITA A. KORELL, MD | | 111 Penn Stre | et,Baltimor | re,MD 212 | 201 vo | |



| 1 - STATE REGISTRAR | SIAIE OF | MARTLAND | | ICATE (| | | MENIA | REG. NO. | | | |
|---|----------------------|---|--------------|-----------------|------------|------------------------------|------------|-----------------------------|-------------|----------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | BABY I | IMOTHY | CI | RBEA | м 1.1 р |) | 2. OATE | OF DEATH | ı. | YEAR | 3. TIME OF DEATH |
| (TIMOTH 4) | | Y) 545 69 1 | | INDE A | 1 0 1 | | mort | | - | OF | 819/Am M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs, In | | IF UNDER 1 Y | | UNDER 24 HRS. | 7. DATE | OF BIRTH | 3 | a. BIRTHE Country | PLACE (State or Foreign |
| NONE | 1 💢 🎾 2 🗆 F | | YRS. | 02 | | | | th, Day, Ybar) - 30 - 9 | 0 | | MD. |
| 9e. FACILITY NAME (If not institution, give st | | | | | | OCATION OF | | | 9c. COU | NTY OF DE | EATH |
| FRANCIS SCOTT | KEY ME | ED. CTF | ₹. | В | ALT: | IMORE | , MC |) | | | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | , | | 10c. CIT | Y, TOWN OR L | LOCATION | | | | | | 10d. INSIDE CITY |
| MD | | | BAI | TIMO | RE, | CITY | | | | | LIMITS? |
| 10e. STREET AND NUMBER | | | | | 10t. ZIP | CODE | | | 10g. CIT | ZEN OF W | HAT COUNTRY? |
| 2324 E. BIDDL | E STREE | ĒΤ | | | | 21213 | | | | US | A |
| 11. MARITAL STATUS | 12. WAS DECEOEN | T EVER IN U.S. A | RMEO | | | ENT OF HISP/ Cuban, Maxic | | N? (Specify Yar | or No- | 14. RACE Black | — American Indian, White, etc. |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE | MAR OR DATES | V.O | | YES 2 | | | ricali, etc.) | | Specif | |
| 15. DECEOENT'S EDUC (Specify only highest grade | CATION completed) | 16a, O | ECEOENT'S | USUAL OCCU | JPATION | Lundina | 16 | b. KIND OF BU | SINESS/IN | DUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | +) | e. Do NOT us | se retired.) | ng moor or | WORKING | | | | | |
| CHILD | | | CHIL | D | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 16 | | | Middle, Maiden | | | |
| TIMOTHY CURBE | AM SR. | | | | | | | TE Mc(| | | |
| 190. INFORMANT'S NAME (Type/Print) CHARLETTE | McCOY | 1 | 96. MAILING | | | | | nber, City or Tow BALTIN | | | . 21213 |
| 20a METHOD OF DISPOSITION 1 D Burlal 2 Cremation 3 Rem | numi team State | 20b. PLACE | OF DISPOS | SITION (Name | of cometer | ry, crematory or | 0.0.5.4 | 20c. LO | CATION - | City or Toy | vn, Stata , MD. |
| 4 Donation 5 Other (Specify) | | _ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | SHEL! | | ORI | AL GA | RDEN | 12 B | 4L 1 | MUKE | , MU. |
| | Maril | 1 | | | | | | | | | |
| Cruch W. | nank | | | WM. | С. | MARCH | F. | 1. 110 |)1 E | .NOR | TH AVE. |
| 23. PART I. Entar the diseases, or o shock, or heart failure. | | | | not antar th | a moda | of dying, au | ch aa ca | rdlac or reap | iratory an | rest, | Approximata Interval Batween |
| IMMEDIATE CAUSE (Final | 4 | | | | | | | | | | Onaat and Death |
| disease or condition reaulting in death) | a. ACUT | E UP | PER | A11 | 2WK | 74 0 | BS | TRUC | 710 | W | <2hrs |
| | _ | | | | | | | | | | |
| Sequantially list conditions, | b. SUB | GLO T | //C | D/1 | E NU | 0315 | | | | | ~ LWKS |
| If any, leading to immediate cause. Enter UNDERLYING | 70 | mATU | | 4 | | | | | | | j |
| CAUSE (Disease or Injury that initiated events | oue To | OR AS A CONS | EOUENCE O | F): | | | | | | | |
| reaulting in death) LAST | d, | | | | | | | | | | |
| PART II. Other significant condition | e contributing to | death but not | maultina | In the unde | dulan or | oues whee I | Dort I | 24a. WAS AN | AUTODOV | 045 | WERE AUTOPSY FINDINGS |
| PART II. Other significant condition | eonanbating to | daadii but iiot | reauting | in the unde | niying ca | ause givan i | reart I. | PERFO | RMED? | 240. | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | 1 TYES | NO | | DF DEATH? |
| | | | | | | | | | | | 1 TYES 2 THO |
| 25. WAS CASE REFERRED TO MEDICAL | | | | - | 26. PI ACE | E OF DEATH (C | hack ook | nnel | | | |
| EXAMINER? | HOSPITAL: | ☐ ER/Outpatient | 2 □ 004 | OTHER: | | 5 Residence | - 1 | | | | |
| 27. MANNEB-OF DEATH | 28a. DATE O | F INJURY | 28b. TIN | E OF 28 | c. INJURY | / AT | _ | EŞCRIBE HOW | NJURY OC | CURED | |
| 1 Natural 5 Pending | (Month, i | Day, Year) | IN. | JURY M | WORK? | 2 🗌 NO | | | | | |
| 2 Accident Investigation 3 Suicide 8 Could not be | 26a. PLACE | OF INJURY — At 1 | ome, farm, | street, factory | , office | | 281. LO | CATION (Street | and Numbe | r or Rural R | loute Number, |
| 4 Homicide detarmined | pullaling | , atc. (Specify) | | | | | Cit | y or Town, State | | | |
| 29a. CERTIFIER (Check only 1 CERTIFYING PHYSI | CIAN: To the best o | t my knowledge. | leath occur | red at the time | , date and | d place, and de | e to the c | ause(s) and ma | nner aa sta | nted, | |
| one) 2 MEDICAL EXAMINE | | | | | | | | | | |) and manner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIE | // | | | | 29 | c. LICENSE N | JMBER | _ | 29d. DAT | TE SIGNED | (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAL | | | | 12 | 1) To | 20 | <u>J</u> | | -/- | 10/90 |
| FRANCIS S | DTT A | KEYN | 1EDI | CAL | CT | R, I | 341 | TIME | RE | | |
| DEC 14 1990 | | AR'S SIGNATURE | | | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transi be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

OHMH-18 Rev 1/89

96 41 41

Miter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at

BY PHYSICIAN: MEDICAL CER

BE COMPLETED

2

TO THE HOSP TO THE HOSP be filed with

| 13146, | executed within |
|----------|---------------------|
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| P.O. BOX | h certificate |
| σ. | at the death |
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| RECORDS | requires |
| | AMP. |
| ₹ | The |
| OF VITAL | HYSICIAN: |
| | 9 |
| disivia | ALCOHOLD STATESTICS |

| | | | 90 34228 | | | |
|--|--|--|--|--|--|--|
| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH | MENTAL HYGIENE REG. NO. | 30 34228 | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) STUAFT, CASSE 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 770 01 6915 1 Ma 2 F 7 L YRS. MONTHS DAYS HOURS MIN. | 2. DATE OF DEATH MONTH 30 7. DATE OF BIRTH (Month, Day, Year) 081414 | YEAR 3. TIME OF DEATH 4 S. BIRTHPLACE (State or Foreign Country) | | | |
| HOL | 98. FACILITY NAME (If not institution, give street and number) 99. FACILITY NAME (If not institution, give street and number) 99. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) 91. CITY, TOWN OR LOCATION OF DEPTH (INSTITUTION OF DEPTH (I | EATH 9c. C | OUNTY OF DEATH | | | |
| DIRECTOR | MARYLAND 106. COUNTY 106. CITY, TOWN OR LOCATION BALTIMORE | | 10d. INSIDE CITY LIMITS? 1 1 1 1 1 1 1 NO | | | |
| UNEHAL | 2133 DENISON 97 2121 | 1 | CITIZEN OF WHAT COUNTRY? | | | |
| 1 1 | 11. MARITAL STATUS 1 Never Married 1 Never Married 2 Married 12. WAS DECEDENT EVER IN U.S. A RIMED FORCES? 1 YES 2 NO If YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPAI If yes, specify Cuben, Market 1 YES 2 NO Specifi | n, Puarlo Rican, atc.) | 14. RACE — American Indian, Black, Whita, atc. Specify: | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. FATHER'S NAME (First, Middle, Last) 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY 18b. KIND OF BUSINESS/INDUSTRY | | | | | | |
| 20 3 | 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NA UNIX KALLONG UNIX KOLONG | ME (First, Middle, Malden Surnam | 9) | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) MRS JABIOER B'ERRY 2/33 DENISON ST | | Zip Code) (D 21216 | | | |
| | 20s. METHOD OF DISPOSITION 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | BALT | - City or Town, State | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FA JOSEPH LL Z222 W. Llo | Russ F. H | 21216 | | | |
| | 23. PART i. Enter the diseases, or complicatione that caused the deeth. Do not enter the mode of dying, such ehock, or heart failure. List only one cause on each line. | h ae cerdiec or reepiratory | arrast, Approximate interval Between Onset and Death | | | |
| | immediate CAUSE (Final disease or condition resulting in death) • CANDIONES IN ATONG ARREST | | 5,500,410,50411 | | | |
| FICATION | Sequentielly list conditione, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events SEPSIS DUE TO (OR AS A CONSEQUENCE OF): DE UMS/ TWS UULT DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| - | und minora avona | | | | | |

1 Natural

2 Accident

3 Suicide

4 🗌 Homicide

PART II. Other significent conditions contributing to deeth but not resulting in the underlying ceues given in Part i.

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 NO

1 TYES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Dinpetient 2 ER/Outpetient 3 DOA OTHER:
4 □ Nursing Home 5 □ Rasidence 8 □ Other (Specify)

1 YES 2 NO 27. MANNER OF DEATH

8 Could not be determined

d.

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY

28c. INJURY AT WORK? 1 YES 2 NO 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(e) and menner as stated.

2 ___ MEDICAL EXAMINER: On the basia of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner as stated.

29d. DATE SIGNED (Month, Day, Year)

296. SIGNATURE AND TITLE OF CERTIFIER M. D.

296. LICENSE NUMBER
D2405

1/2

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

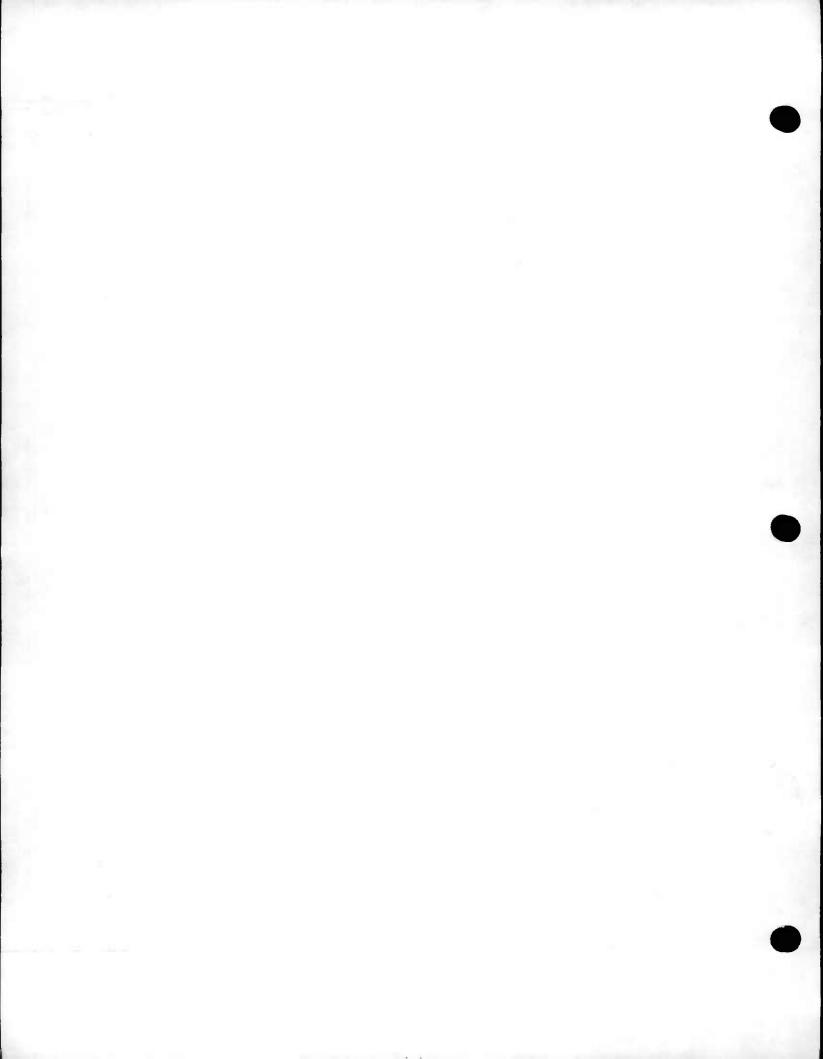
EDUARDO P. LAYUL: 76 to 4 CRK MD.; TOWSON Md.

31. DATE FILED PROPER. On, Apr. 1990
SCHEGISTAN'S SIGNATURANCE.

| TO THE HOSPITM STATES AND TRIBINANT. The law requires that the death certificate be executed within co. Hours after death. Page 6 may be retained by the hos | TO THE FUNE AND THE TOWN THE TIME CONTROLLED BOOK SIGNED BY THE Attending physician and completely filled in by the funeral director, page 5 should be detached to the standard of removal | De filed Within 22 notes and man are Just Dept. Or regard and mental righters print to content, the medical examiner must be notified at once. |
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| be n | age 5 | De n |
| 6 тау | tor, p | net |
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| withir | pletel | c event, the medical exa |
| cuted | od con | tic e |
| De exce | lan ar | эпша |
| Scate | physic | er tr |
| certif | Ding | r of |
| death | e atter | 7, |
| at the | by th | y in |
| res th | gned | 15 an |
| requi | S La | show |
| e law | has b | 123 |
| N. S. | ficate Ctoto | Item |
| Sign | PHO 8 | d, 01 |
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| 3 | 7 | # III |
| 10SPI | UNE | ANI |
| THE | THE | PORT |
| 2 | 2 | 2 ₹ |

| | FOR 1 - STATE REGISTRAR | STATE OF M | | | RTMENT | | | | MENTAL | HYGIEN REG. NO. | E 90 | 0-3 | 4229 |
|----------------|---|--------------------------|-------------------------------------|------------|----------------------------|--------------|----------------------|-----------|-------------------------|-------------------------------|-----------------|-------------|---|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | 0.2 | | IOAIL | | DEA | | 2. DATE OF | | | YEAR 3 | LUME PROJECT |
| i | Ruby | CORBETT | | | | | | Dec | 11. | 1990 | TEAH 1 | l:44 a ™ | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. lest | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF (Month, I | Day Year) | | Country) | LACE (State or Foreign |
| | 235-34-0176 | 1 🗆 M 2 🔀 F | 65 | YRS. | | | | | | :h24 | _ | | stVirgiri |
| œ | 9a. FACILITY NAME (If not institution, give a Franklin Squa | are Hos | pital | | 9b. CITY | , TOWN C | R LOCATIO | | eath Ville | | | timor | re Co. |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | 1 | | K | 055 | ATTTE | 2 | Dui | CTIIIOT | |
| H. | 10s. STATE 10b. COUNT | BAlti | nore | 10c. CIT | TY, TOWN | R LOCAT | ION SSCI | ale | | | | 1 | IOd. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | 21.2 - 2. | | | | | , ZIP CODI | | | | T 40 - 0/7/ | | I ☐ YES 2∑☐ NO |
| RA | 1833 WEyburn | Desei | | | | 101 | | : 1231 | 7 | | 10g. C1112 | USA | IAI COUNTRY? |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | IT EVER IN U.S. ARM | | | | ENDENT C | OF HISPAN | VIC ORIGIN? | | or No— | 14. RACE - | - American Indian, |
| BY F | 1 Never Merried 2 Married 3 Vidowed 4 Divorced | FORCES? 1 | YES 2 NAR OR DATES | 0 | | | ecity Cube 2 □KNO | | n, Puerto Ric | cen, etc.) | | Specify | White, etc. |
| | 15. DECEDENT'S EDU | CATION | tto DEC | PEDENTS | USUAL O | COLIDATIO | 201 | | 405.0 | CAND OF BUI | SINESS/INO | LICTOV | White |
| ETED | (Specify only highest grade Elementary/Secondery (0-12) | | (GA | re kind of | work done ise retired.) | durina mo | st of working | ng | 100. F | OND OF BU | SINESS/INO | 031111 | |
| | 12th | Comage (1-4 of 3 | | Acc | our | ting | à | | | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Lest) | | | | | | 18. MOT | | ME (First, Mic | | , | | |
| BE | | Deputy | | | | | | | ttie | | oely | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | Janka Lt | 196 | | | | | | Route Number | | | - | 21237 |
| | 20s. METHOD OF DISPOSITION | Corbett | 20b. PLACE (| OF OISPO | | | | | GIG DE | _ | CATION — | | |
| | 1 Buriel 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | loval from State | other ple | | ns o | of E | ait | h | | | Ross | svil | le |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 1.11 | 1 | 22. | NAME A | ND ADDRE | SS OF FA | | | | | |
| , | (onnelly | Funer | of H | - | 0) | Conr | 1e11. | уFu | nera. | Hone | e3001 | MACE | Ave21221 |
| | 23. PART i. Enter the diseases, or ahock, or heart fallure. | | | | not ente | the mo | de of dy | ing, suc | h as cerdi | ec or resp | Iratory arr | eat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel | /n. | A Se on each inte. | 0 | , | ~ | D | | A- | | | | Onset and Death |
| | disease or condition resulting in death) | · My | o Cero | les | 12 | 1 | No | ~ | m | * | | | |
| _ | | DUE TO | OR AS A CONSEC | UENCE (| OF): | | 1 | | • | | | | |
| ERTIFICATION | Sequentially list conditions, If eny, leading to immediate | bDUE TO | (OR AS A CONSEC | UENCE (| OF): | | | | | | | | |
| 8 | cause. Enter UNDERLYING CAUSE (Disease or injury | C | | | | | | | | | | | |
| | that initiated events resulting in death) LAST | DUE TO | (OR AS A CONSEC | UENCE (| OF): | | | | | | | | |
| EH CH | | d | | | | | | | | | | | |
| CAL | PART II. Other algnificant condition | ne contributing to | death but not n | eaulting | In the u | nderlyin | g cause | given in | Part I. | 24a. WAS AP PERFO | | | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| _ | | | | | | | | | _ | t 🗌 YES | 2 NO | | COMPLETION OF CAUSE OF DEATH? |
| Z | | | | | | | | | _ | | | | 1 TES 2 NO |
| PHYSICIAN: MED | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26 P | ACE OF I | SEATH (C) | neck only one | 1 | | | |
| 딩 | EXAMINER? | HOSPITAL: | ☐ ER/Outpatient 3 | □ DOA | OTHE 4 Nu | R: | | | 8 Other | | | | - |
| Ě | 27. MANNER OF DEATH | 26a. DATE O | F INJURY Day, Year) | 28b. TI | _ | 28c. IN. | JURY AT | | | | INJURY OC | CURED | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | | | М | | YES 2 [| □ NO | | | | | |
| | 3 Suicide 6 Could not be | 26s. PLACE (building | OF INJURY At ho , etc. (Specify) | me, farm, | , street, fac | ctory, offic | 10 | | | TION (Street r Town, State | and Number) | or Rural Ro | oute Number, |
| | no continue | A | | | | / | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMIN | FR: On the basis of | | | | | | | | | | | and manner on stated |
| | 29b. SIGNATURE AND TITLE OF CONTIN | | parintalitori attaori | | ion, in my | ориноп, с | | ENSE NU | | rno prece, a | _ | | Maria American |
| B | Dal Jak | ar lm | 0 | | | | 1 | () [| 17 | 7_ | ≥ / | 2/11/ | (Month, Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAL | ISE OF DEATH (ITE | M 27) (Typ | oe, Print) |) | | 0 0 | <i>b l</i> | _ | 1- | 1 10 | 1. |
| | 6402/6 | 3 CHOC | WKI | V | G 1 | (n | R | AL | 5 1 | 1D. | - 21 | 23 | 7 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTA | Davidson-V | Bords | 12 | | | | | 1000 | | | |
| | DEC 14 19 | 90 Julia | MENICOUNTY | 1-100 | - | | | | | | | | DANIEL 16 Day 178 |

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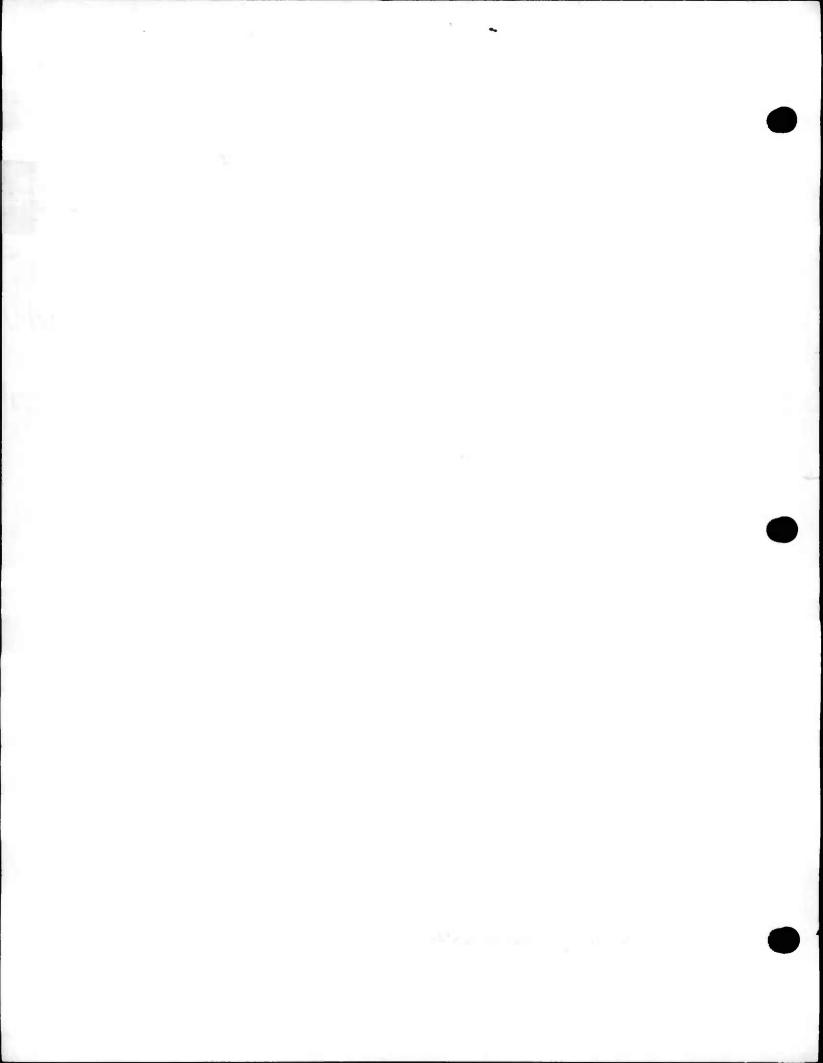
exist, requires that the death certificate be executed within the cours after death. Page 6 may be retained by the hospital or attending physician.
That been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. The law requires that the death certificate be executed within TO THE HOSPITAL OR ATTENDING PHYS. IN THE FUNERAL DIRECTOR: After this be filed within 72 hours after death with IMPORTANT: If Item 28 is market.

| | 1 - STATE STATE CERTIFICATE OF DEATH REG. NO. |
|--------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH TEAR 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birtifles) FUNDER 1 YEAR FUNDER 24 HRS. 7. DATE OF BIRTH Country Number |
| ~ | See, FACILITY, MAINE (It propersionalities), Say stopes and number) 96. CITY, JOWN OR LOCATION OF DEATH 96. CITY, JOWN OR LOCATION OF DEATH |
| CTO | RESIDENCE OF DECEDENT PROPERTY AND GATUMOT, MY |
| DIRECTOR | 10e. STATE 10e. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1/□ yes 2 □ NO |
| FUNERAL | 100. STHERT AND NUMBER 101. ZIP CODE 100. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE 102. CITIZEN OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Merried 2 Merried 1 Never Merried 4 Divorced 1 Vidowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 DIES 2 NO If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 13. WAS DECEDENT OF HISPANC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Ricen, etc.) 1 VES 2 A Specify: |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) (Give kind of work done during most of working the Do NOT use retigod.) |
| MPLE | Elementary/Secondary (0-12) College (1-4 or 5+) Machine Operation Auction Col |
| BE COI | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meltion Surname) |
| TO B | 190 (HIP ORIMANT'S NAME (TYPO-Print) VIVIAN MALLING ADDRESS (Strong on Paint Assembly proper Gity or Eight, Stone, Zip Gogle) 4502 Franklight APF-28 Bally 45125 |
| 1,000 | 20e_METHOD OF OISPOSITION 15/ Burtel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) |
| | 21. SIGNATURE OF FUHERAL SERVICE LICENSEE RODNEY FUNERAL SERVICE OFFICES 4644 PIMLICO ROAD |
| | 23. PART I. Enter the diseases, or complications that couled the death. Do not enter the model of the country o |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Show CARDIAC DEATH 20 ARRHYHMIA MINS. |
| z | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING LOGING LO |
| TIFIC | CAUSE (Disease or injury that initiated events resulting in death) LAST |
| CER | d |
| CAL | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Very completion of Cause 1 Very completion of Cause 1 Very completion of Cause 1 Very completion of Cause 1 Very completion of Cause 1 Very completion of Cause 1 Very completion of Cause Very compl |
| PHYSICIAN: MEDICAL | 1 YES 2 DNO OF DEATH? 1 YES 2 DNO |
| AN: | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) |
| SICI | EXAMINER? 1 D TES 2 NO 1 Inpetion 2 DER/Outpetient 3 DA 4 Nursing Home 5 D Residence 8 Other (Specify) |
| PHY | 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED |
| B | 1 Metural 5 Pending 2 Accident Investigation 3 Suicide 8 Could got be 28. PLACE OF INJURY — At home, farm, street, factory, office 28. PLACE OF INJURY — At home, farm, street, factory, office 28. PLACE OF INJURY — At home, farm, street, factory, office |
| ETEC | 3 Sucrose 8 Could not be building, etc. (Specify) City or Town, State) |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as attated. |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIER MD D 18882 12/13/90 |
| 2 | 30. NAMEYNO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JENNIFER HAMILTON M). V. A. MEDICAL CENTER 1 3900 LOCH RAVEN BLVD 30. NAMEYNO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JENNIFER HAMILTON M). V. A. MEDICAL CENTER 1 3900 LOCH RAVEN BLVD 30. NAMEYNO ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) |
| | 31. DATE FILED MOON, DOWN JOHN STRANGE SIGNATURE DE C 14 1990 Juli Davidson-Randale |

Source Ardinal Association of Tool

| Ų. | ₹ | 5 | i |
|--|---|--|----|
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 29 | THE FUNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely fill | sled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, | |
| uted v | COM | mal, c | 4 |
| Oeco C | n and | to bu | 14 |
| 2 | icia | 10, | - |
| ificate | phys | ane pi | 1 |
| h cert | ending | Hygi | 4- |
| deat | e atte | Jental | |
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| that | d b | h a | |
| nires | signe | Healt | |
| 5 | Deen Deen | 0 | |
| W. | 98 |)ept | |
| E e | te h | ate [| |
| N. | ifica | St | ; |
| SiC | cert | th. | |
| PHY | this | with | |
| DING | After | death | |
| TEN | TOR | after | |
| OR A | OIREC | hours | |
| M | K | 2 | |
| HOSPI | FUNER | within | ļ |
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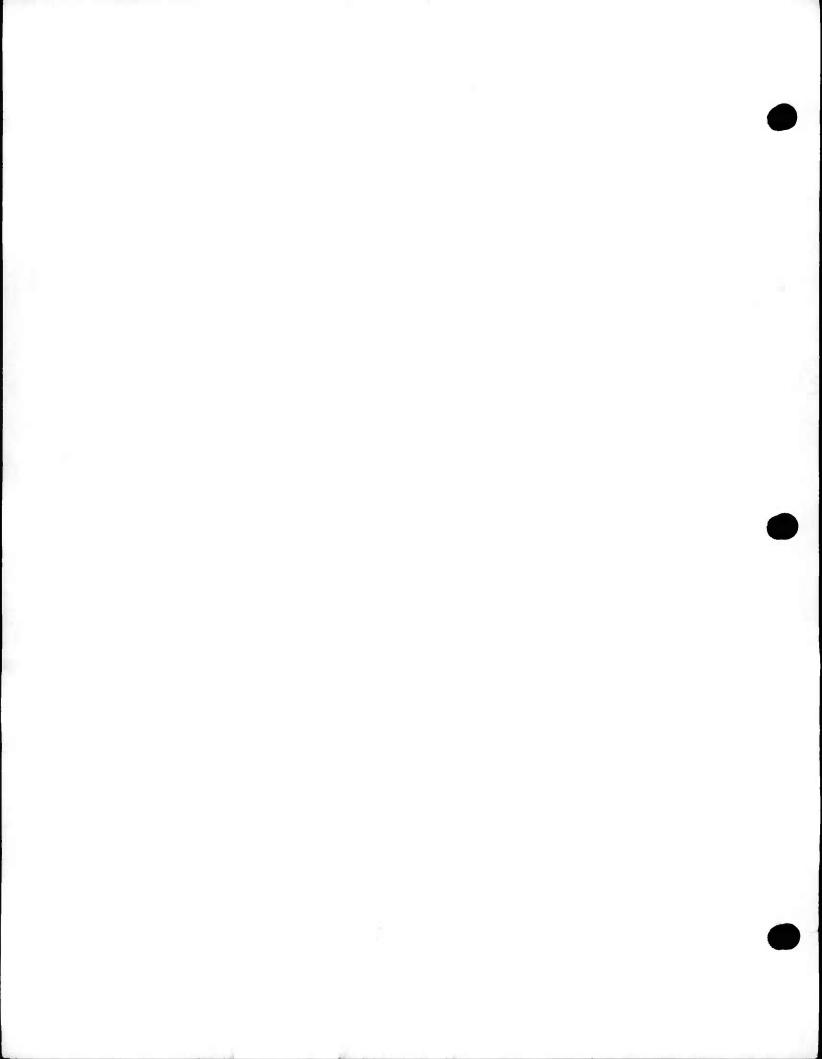
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT OF | | MENTAL HYGIENI REG. NO. | | |
|---------------|--|--|----------------------------|--|---|--------------------|--|
| | 1. OECEDENT'S NAME (First, Middle, Last) | 0 0 | | | 2. DATE OF DEATN MONTH DAY | Y YEAS | 3. TIME OF DEATH |
| | | dmondo | | | 12 9 | | 10:07 PM |
| | 215 72 2772 | 6. AGE (In yrs. lest | VRS. IF UNDER 1 YEA | | 7. DATE OF BIRTH (Month, Day Year) | 8. BIF | RTHPLACE (State or Foreign unitry) |
| <u>س</u> | 9a. FACILITY NAME (If not Institution, give street CHURCH HOSPIT | | | N OR LOCATION OF OE | ATH | 9c. COUNTY O | F DEATH |
| Ę. | RESIDENCE OF DECEDENT | TIM COM ONATI | | | | | |
| DIRECTOR | 10a. STATEMD 10b. COUNTY | | BALTIM | ORE CITY | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 10e. STREET AND NUMBER | | | 10f. ZIP COOE | | 10g. CITIZEN O | F WNAT COUNTRY? |
| FUNERAL | 1818 N BROADWA | | | 21213 | | M | 51 |
| B≺ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 2. WAS DECEDENT EVER IN U.S. ARIN FORCES? 1 YES 2 TH IF YES, GIVE WAR OR DATES | U If yes | DECENDENT OF NISPAN , specify Cuban, Maxica YES 2 NO Specify | | or No— 14. R. | ACE — American Indian, lack, Whita, etc. pocity: |
| 8 | 15. OECEOENT'S EDUCAT (Specify galy nightest grade con | (ION mpleted) 16a. DEC | CEDENT'S USUAL OCCUP | ATION a most of working | 18b. KIND OF BUS | INESS/INOUSTR | Y |
| COMPLET | Elementery/Secondary (0-12) | College (1-4 or 5+) | DO NOT use retired.) | | _ | | |
| O. | 17. FATRER'S NAME (First, Middle, Last) | 0 - | | 16. MOTHERIS NA | ME (First, Middle, Milden | Surname) | |
| б ш | John y | 6 ouser | | Kor | U Sin | unier | rs |
| TO B | 19a. INFORMANT'S NAME (Type/Print) | V 196 | MAILING ADDRESS (Str | eet and Number of Rural I | Poute Number, City or Town | n, State, Zip Code | r.md |
| | 20m METHOD OF JISPOSITION 1 Jurial 2 Cremation 3 Remova | | OF DISPOSITION (Name o | cemetry, crematory or | 20c. LO | CATION — City of | r Town, Stata |
| | 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | 22. NAM | E ANO ADDRESS OF FA | CILITY | nes | may |
| | · Bett France | und Home | 0 11 | 29 NX | Cerelin | 254 | <u> </u> |
| | 23. PART I. Enter the diseases, or con | mplications that caused the dec | ath. Do not antar tha | mode of dying, auc | h as cardiac or respi | ratory arrest, | Approximata |
| | IMMEDIATE CAUSE (Final | at only one cause on each line. | - 101 | | | | intarval Between Onset and Death |
| | disease or condition a | Cu | culatory | Cellapse | | | |
| _ | | DUE TO (OR AS A CONSEC | NINE CLOCK | Olsan - | Failure. | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSECUENT OF AS | UENCE OF): | Ocar | · · · · · · · · · · · · · · · · · · · | | |
| FIC | CAUSE (Disease or injury that initisted events | OUE TO (OR AS A CONSEC | UENCE OF): | an uni | ma | | |
| ERT | resulting in death) LAST | | | | | | |
| | PART II. Other algorificant conditions | contributing to death but not re | aulting in the under | lying causa givan in | Part i. 24e. WAS AN | | 24b. WERE AUTOPSY FINDINGS |
| JICAL | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDI | | | | <u> </u> | _ | | 1 YES 2 NO |
| N. | | | | | | | |
| PHYSICIAN: | | HOSPITAL: | OTHER: | 6. PLACE OF DEATN (Ch | | | |
| HYS | 1 YES 2 NO 1 27. MANNER OF DEATN | 28a. DATE OF INJURY | 28b, TIME OF 26c | Home 5 Realderica | 6 ☐ Other (Specify) 26d. DEŞCRIBE HOW I | NJURY OCCURE | 0 |
| BY PF | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY M 1 | WORK? | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28s. PLACE OF INJURY — At hor building, atc. (Specify) | ma, farm, street, factory, | office | 28f. LOCATION (Street a City or Town, State) | and Number or Ru | rral Route Number, |
| COMPLETED | cond only | AN: To the best of my knowledge, de- On the basis of examination and/or i | | | | | se(a) and manner se stated. |
| B | 296. SIGNATURE AND TITLE OF CERTIFIER | Boshan ! | no | 29c. LICENSE NUI | 594 | | NEO (Month, Day, Year) |
| 12 | 30. NAME AND ADDRESS OF PERSON WHO CHURCH HOSPITA | COMPLETEO CAUSE OF DEATH (ITEM | 4 27) (Type, Print) | | | | . // - |
| 1 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | DWAI [| DR: BOHAI | KKT | | |
| | DEC 14 1990 Su | he Davidson Andre | • | | | | |



permit. Pages 1, 2, 3 should

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND N | MENTAL HYGIENE |
|--|----------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPART | | | | HYGIENE REG. NO. | | | |
|------------------|--|---|-----------------------|----------------------------|--------------------------|----------------|---------------------|------------------|--------------------------|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) JOHN EVANS / To | ohn Howard | Fyans | | | 2. DATE OF | DAY | 10 199 | AR | e of DEATH |
| | | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | | | | (State or Foreign |
| | 230 10 0010 | 1 m 2 □ F 57 | YRS. | IONTHS DAYS | HOURS MIN. | 10- | Day, Year) -5-33 | 0 | Country) N. | С. |
| FUNERAL DIRECTOR | 9a. FACILITY NAME (If not institution, give stree | | | | R LOCATION OF DE | ATH | | 9c. COUNTY | OF DEATH | |
| | THE JOHNS HOPKIN | NS HOSPITAL | | BALTIMO | RE CITY | | | BALTI | MORE | CITY |
| គ្ន | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c, CITY. | TOWN OR LOCAT | ION | | | | 10d, II | SIDE CITY |
| E | MD | | D A | LTIMOR | E CITY | U7 | | | | MITS? YES 2 NO |
| ادّ | 10e. STREET AND NUMBER | | I DA | | ZIP CODE | 1 | | 10g. CITIZEN | | |
| R | 26 South Exeter | . Chuash | | | 1010 | | | | | |
| ž | 11. MARITAL STATUS | 2. WAS DECEDENT EVER IN | U.S. ARMED | - | 1218 ENDENT OF HISPAN | IIC ORIGIN? | (Specify Yea | or No— 14. | | erican Indian. |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2-1- NO | If yes, sp | z NO Specify | n, Puarto Ric | en, atc.) | | Black, White Specify: | erican Indian, , atc. |
| B | 3 🖺 Widowed 4 🗌 Divorced | | | 1 | z [] iie opony | ·· | | | | LACK |
| | 15. DECEDENT'S EDUCAT (Specify only highest grade co | | 18a. DECEDENT'S U | SUAL OCCUPATION OF COMPANY | ON et of working | 18b. K | IND OF BUS | INESS/INDUST | RY | |
| ᄪ | | College (1-4 or 5+) | life. Do NOT use | retired.) | a or worning | | | | | |
| P P | 5th Grade | | Unemp1o | ved | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Mic | ddle, Maiden | Sumame) | | |
| BE (| Issac | Evans | | | Geneva | | T | rafto | n | |
| 10 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | nd Number or Rural I | Route Numbe | r, City or Town | , State, Zip Coo | de) | |
| - | | Evans | | | Y ST./I | Balti | Imore | Md. | 212 | 1.8 |
| | 20s METHOO OF DISPOSITION 1 Parial 2 Cremation 3 Remove | al from State | other place) | TION (Name of cer | netery, crematory or | | 20c. LOC | CATION — City | or Town, Sta | rta |
| | 4 Donation 5 Other (Specify) | | lestern | | | | Cat | onsvi | 11e, | Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE | | 22. NAME A | ID ADDRESS OF FA | CILITY | | | | |
| | UMIGHT COM | | | WM.C. | March 1 | F.H. | 1101 | E. N | ORTH | AVE. |
| | 23. PART I. Enter the diseases, or collaboration in the part fellure. List IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | et only one ceuse on e | ech line. | | de of dyling, suc | h es cerdi | ec or respli | retory erreet | | Approximate interval Between Onset and Deeth |
| 2 | | DUE TO (OR AS A | A CONSEQUENCE OF) | • | | | | | | - |
| ATIO | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | | | | | | | | | |
| E | d | | | | | | | | | |
| CAL | PART II. Other eignificant conditions | PERFORMEO? AM | | | | | | | | AUTOPSY FINDINGS ABLE PRIOR TO LETION OF CAUSE |
| PHYSICIAN: MEDI | | | | | | | | | YES 2 NO | |
| 2 3 | | | | | | | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | 28. P | LACE OF OEATH (Ch | neck only one |) | | | |
| Sic | | HOSPITAL: 1 Inpatient 2 ER/Outp | patient 3 DOA | OTHER: 4 - Nursing Hon | ne 5 🗆 Realdence | 8 🗆 Other | (Specify) | | | |
| Ŧ | 27. MANNER OF DEATH | 28a. OATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c. IN. | JURY AT ORK? | 28d. DESC | CRIBE HOW II | NJURY OCCUR | ED | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (monn, bay, rea) | | | YES 2 NO | | | | | |
| COMPLETED B | 3 Suicide 8 Could not be 4 Homicide determined | Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office 28t. LOCATION (Street and Number or Rural Route City or Found State) | | | | | | Rural Route A | lumber, | |
| 9 | 29a. CERTIFIER 1 CERTIFYING PHYSICI | AN: To the beat of my know | riedge, death occurre | d at the time, date | and place, and due | to the caus | ne(s) and mer | mer se stated | | |
| M | one) | On the besis of examination | | | | | | | ause(s) and | manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NU | MBER | | 29d. DATE S | IGNED (Mont | h. Dav. Year) |
| B | 200-11 | (| | | 29c. LICENSE NUMBER 29d. | | | | | 41) |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | EATH (ITEM 27) (Type, | Print) | | | | | 114 | · · |
| | Eirim CHA | MUNHAT | JUH | ns H | epkno | He | pit | 22 | | |
| | DFC 1 4 1990 | 32. REGISTRAR'S SIGN | Anda M. | | | | | | | |



BALTIMORE, MARYLAND 21203-3146

Pages 1, 2, 3 should

permit.

DIRECTOR

FUNERAL

BY

COMPLETED

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2

filled in by the fi completely filled rial, cremation, The law requires that the death certificate be executed within ysician and com prior to burial, o attending physician ntal Hygiene prior to OR ATTENDING DIRECTOR: After hours after death

CERTIFICATION

PHYSICIAN: MEDICAL

BY

COMPLETED

BE

2

BOX 13146,

P.O.

OF WITAL RECORDS,

funeral director, page 5 should be detached for use as the burial-transit nours after death. Page 6 may be retained by the hospital or attending physician. notified at must be examiner medicai the traumatic event, other t 9 nas been signed by the attend e Dept. of Health and Mental Hy m 23 shows any injury, or marked, or Hem 28 tem TO THE HOSPITAL TO THE FUNERAL I be filed within 72 h

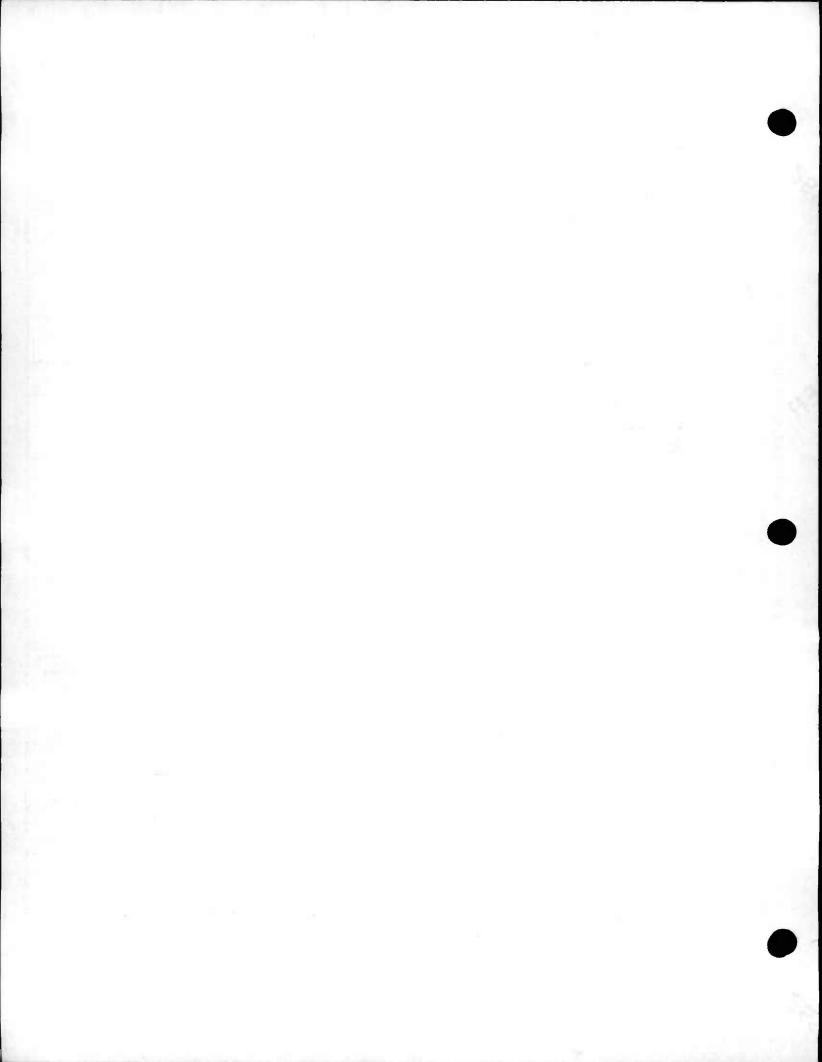
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1 DECEDENT'S NAME (First Middle Last) 2. DATE OF DEATH 3. TIME OF DEATH 12-12-90 Fletcher Michael Ε. 7:21PM 4. SOCIAL SECURITY NUMBER IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Foreign 214-11-2188 1 M 2 F 19 10-31-1971 Md 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH University Hospital Baltimore City RESIDENCE OF DECEDENT 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY 10e STATE 10b. COUNTY 1 YES 2 NO Md Baltimore 10e. STREET AND NUMBER 101, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 140 Palormo Avenue 21229 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerto Rican, atc.)

1 YES 2 NO Specify: 1 Never Married 2 Married Specify: Black. 3 Widowed 4 Divorced 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15 DECEMENT'S FOLICATION 185 KIND OF BUSINESS/INDUSTRY (Specify only highe College (1-4 or 5+) Elementary/Secondary (0-12) 16. MOTHER'S NAME (First, Middle, Meiden Surname) 17. FATHER'S NAME (First, Middle, Last) Lula Davis Robert Fletcher 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lula[&]Robert 140 Palormo Avenue Baltimore, Md 21229 20e, METHOD OF DISPOSITION
1 💢 Burtel 2 🗆 Cremation 3 🗆 Removal from State 20b. PLACE OF OISPOSITION (Name of cemetery, cremetory or other place) 20c. LOCATION — City or Town, State King Memorial Park Randallstown, Md 4 Donation 6 Other (Specify). 22. NAME AND ADDRESS OF FACILITY 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Willie March F/H West 4300 Wabash Avenue 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, Approximete shock, or heart failure. List only one cause on each line. Interval Betwe Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) Multiple gunshot wounds DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? YES 2 | NO DF DEATH? XIX YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) OTHER: XXXXX 2 NO 1 | Inpatient 2 DOST/Outpatient 3 | DOA ne 5 - Residence 6 - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 12-12-90 28d. DESCRIBE HOW INJURY OCCURED 27. MANNER OF DEATH 26b. TIME OF 28c. INJURY AT WORK? Subject shot SHOT BY POLICE 1 Natural 5 Pending Investigati 6:30PM 1 YES ZONO 2 Accident 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) Crazy John's, 304 W. Baltimore PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be Fast food store XX Homicide 29s. CERTIFIER
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner as stated. INSTANCE EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) white fre OCME 12-13-90 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARGARITA A. KORELL, MD 111 Penn Street, Baltimore, MD 21201 31. DATE FILED (Month, Day, Year)

DEC 14 1990 vd 32. REGISTRAR'S SIGNATURE

which Davidson-Randall

DHMH-16 Rev 1/89



Jury after death. Page 6 may be retained by the hospital or attending physician.

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | BALLIMORE, MARYLAND 21203-3146 |
|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 yours after death. Page 6 may be retained by the hospital or attending physic | nours after death. Page 6 may be retained by the hospital or attending physic |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria be filled within 72 hours after death with the State Dept, of Heath and Mental Hygiene prior to burial, cremation, or removal. | id in by the funeral director, page 5 should be detached for use as the buria or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |
| | |

| | REGISTRAR 198/90 | | | CERTIF | | | | | | REG. NO. | - / | 1 n -1 | |
|--|--|--|--|--|------------------------------------|--|--|--|--------------------------------------|---|---------------|----------------------|---|
| - | . OECEDENT'S NAME (First, Middle, Last) | | MELVI | N RUSSI | ELL F | ISHE | R | | 2. DATE | OF DEATH TO | | TEAH | 3. TIME OF DEATH () |
| | MEBVIN FISHER | T | | | _ | | -74 | | 12 | 12 | | 990 | 6050 F |
| | SOCIAL SECURITY NUMBER | 5. SEX | 111- | rs. lest birthday) | IF UNDER | DAYS | HOURS | 24 HRS. MIN. | (Mont | OF BIRTH n, Day, Year) | . 1 | 8. BIRTHP | PLACE (State or Foreign |
| - 11 | 705-05-7296 | 1X M 2 🗆 F | | 3 YRS. | | | | | | <u>/17/0</u> | | | nsylvania |
| | e. FACILITY NAME (If not institution, give s | | | | | , TOWN O | | | ATH | | 9c. COU | NTY OF DE | ATH |
| | CHURCH HOSPITA | L CORPO | RATIC | ON | | BALI | IMC | RE | | | | | |
| 10 | 0e. STATE 10b. COUNTY | Y | | 10c. CIT | ry, town (| OR LOCATI | ON | | | | | | 10d. INSIDE CITY |
| N | MD. | | | | BA | LTIN | /ORF | | | | | | LIMITS? |
| | 0e. STREET AND NUMBER | | | | 2 | | ZIP CODE | | | | 10g. CITI | ZEN OF WI | HAT COUNTRY? |
| | 3102 PINEWOOD | AVE. | | | | | 21 | 214 | | | 11 | C A | |
| or ronenal | 1. MARITAL STATUS | 12. WAS DECEDER | | | | | | | | 17 (Specify Yee | | 14. RACE | - American Indian, |
| 1 | Never Merried 2 Merried | IF YES, GIVE | YES 2 | S NO | | If yes, spe | | n, Mexicer Specify: | | Rican, etc.) | | Specify | White, etc. |
| | Widowed 4 Divorced | -1965 | 5 | | | | Х | | | | | Whi | te |
| | 15. DECEDENT'S EDU (Specify only highest grade | | 184 | e. DECEDENT'S (Give kind of | work done | CCUPATIO during mos | N t of workin | ng | 188 | KIND OF BUS | INESS/IND | USTRY | |
| T COMPLE | Elementary/Secondary (0-12) | College (1-4 or 5 | | Ilfo. Do NOT u | | | | | | | | | |
| | 12 | | | <u>Railway</u> | / Cle | erk _ | | | | B&0 | _ | | |
| 3 17 | 7. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTI | | | Middle, Maiden | | | |
| : <u> </u> | Wilbur Henry | Fisher | | | | | | Ruby | | <u>Bell</u> | Anth | | |
|) " | 9a, INFORMANT'S NAME (Type/Print) | | | 1 | | | | | loute Num | ber, City or Town | n, State, Zip | Code) | |
| | <u>Mrs. Ann Marie Fi</u> | sher | | same | | | | | | | | | |
| 1) | 0a. METHOD OF DISPOSITION X Burial 2 Cremation 3 Hours | ovel from State | MON | ACE OF DISPO her place) reland | Mom | nne of cem Dav | etery, cren | natory or | ۵۸ | | | City or Tow | vn, Stata D. Md. |
| | Donation 8 Other (Special) | townt | 1101 | erand | - | NAME AN | | | | Dai | CIMO | re co | J. MG. |
| 1 | Cont Toks | FORT | | | | eonar | | | | nc. | | | |
| | Frnest I Fai | St 111 | | | | R05 H | | | - | Raltin | ore | Md | 21214 |
| 2 | 23. PART i. Enter the diseases, or | | | | | | | | | | | rest, | Approximete |
| 11 . | shock, or heart fallure. IMMEDIATE CAUSE (Final | List only ona ce | use on each | i iine. | | | | | | | | | Onset and De |
| | disease or condition resulting in death) | . La | relia | wy U | xit | thu | | | | | | | [|
| 1 | resulting in death) | DUE TO | OR AS A CO | NSEGGENCE (| FI: | 0 | | 0 | | | | | |
| z _ | Conserting Heart Scilure_ | | | | | | | | | | | | |
| | Sequentielly list conditions, if any, leading to immediate b. OUE TO (ON AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| : A " | CAUSE (Disease or injury | | | | | | | | | | | | |
| 3 8 | | c | | DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST | | | | | | | | | |
| | CAUSE (Diseese or injury that initiated events | C. DUE TO | OR AS A CO | ONSEQUENCE (| OF): | | | | | | | | |
| to the second | CAUSE (Diseese or injury that initiated events | d. | O (OR AS A CO | ONSEQUENCE (| OF): | | | | | | | | |
| ۱ ا | CAUSE (Diseese or injury that initiated events | d | | | | nderlying | J ceuse | given In | Part I. | 24a. WAS AN | | 24b. | WERE AUTOPSY FINDIN |
| 3 - | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | | | | nderlying | j ceuse | given In | Part I. | PERFOR | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| P P | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | | | | nderlying | j ceuse | given in | Part I. | | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL C | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | | | | nderlying | j ceuse | given in | Part I. | PERFOR | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE |
| P P P | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | d | | | | | | | | PERFOR | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| P P P | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | dns contributing to | o deeth but o | not resulting | othe | 26. PL | ACE OF D | EATH (Ch | eck only o | PERFOR | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| P P P | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL | d | D deeth but i | not resulting | OTHE | 28. PL R: rsing Hom | ACE OF D | EATH (Ch | eck only o | PERFOR | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 10 10 10 10 10 10 10 10 10 10 10 10 10 1 | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Deptilent 2 28e. OATE O | D deeth but i | not resulting | OTHE | 28. PL R: rsing Home 28c. INJI WO | ACE OF D | PEATH (Chi | eck only o | PERFOR 1 YES 2 ne) | MED? | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 15. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Legitlent 2 28e. OATE O (Month, | ER/Outpetle FINJURY Doy, Year) OF INJURY | not resulting | OTHE | 28. PL R: rsing Hom 28c. INJI WO | ACE OF D 5 RIURY AT RK? 'ES 2 [| PEATH (Chi | 8 Oth | PERFOR 1 YES 2 ne) | MED? | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Legitlent 2 28e. OATE O (Month, | □ ER/Outpetle F INJURY Day, Year) | not resulting | OTHE | 28. PL R: rsing Hom 28c. INJI WO | ACE OF D 5 RIURY AT RK? 'ES 2 [| PEATH (Chi | 8 Oth 28d. DE | PERFOR 1 YES 2 ne) pr (Specify) SCRIBE HOW I | MED? | CURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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| | PART II. Other significant condition 15. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 1 Netural 5 Pending investigation 2 Accident 1 Netural 5 Could not be determined 1 Homicide 1 DEERTIFYING PHYS One) 2 MEDICAL EXAMINITY 2 MEDICAL EXAMINITY 2 MEDICAL EXAMINITY | HOSPITAL: 1 Implifient 2 28e. OATE O (Month, 28e. PLACE building | □ ER/Outpetie F INJURY — Day, Year) OF INJURY — ,, etc. (Specify) | not resulting | OTHE 4 Nu ME OF JURY M | 28. PL R: rsing Hom 28c. INJ WO 1 V tory, office | ACE OF D 5 Ri URY AT RK? ES 2 [end place eath occu | NO NO | 281. LOC/ly to the cattline, dat | PERFOR 1 YES 2 Per (Specify) SCRIBE HOW I CATION (Street or Town, Stefe) | NJURY OC | CURED or or Rurel A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
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| OBE COMPLETED BY THISICIAN: MEDICAL CE | PART II. Other significant condition 15. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 17. MANNER OF DEATH 1 Netural 5 Pending investigation 2 Accident 1 Netural 5 Could not be determined 1 Homicide 1 DEERTIFYING PHYS One) 2 MEDICAL EXAMINITY 2 MEDICAL EXAMINITY 2 MEDICAL EXAMINITY | HOSPITAL: 1 Department 2 28e. OATE O (Month, 28e. PLACE building | □ ER/Outpatie F INJURY Day, Year) OF INJURY — p, etc. (Specify) of my knowledgexamination er | not resulting ent 3 □ DOA 28b. Tills At home, farm, ge, death occur | OTHE 4 Nu ME OF JURY M street, fec | 28. PL R: rsing Home 28c. INJI Victory, office time, data opinion, d | ACE OF D 5 Ri URY AT RK? ES 2 [end place eath occu | NO NO | 28f. LOCify to the cattime, det | PERFOR 1 YES 2 Per (Specify) SCRIBE HOW I CATION (Street or Town, Stefe) | NJURY OC | CURED or or Rurel A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NOTE OF CAUSE OF CAUSE OF DEATH? 1 oute Number, Oute Number, Oute Number, Oute Number, |
| COMPLETED BY PRINCIAN: MEDICAL CENTIFICAL CE | CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINITIES. SIGNATURE AND TITLE OF CERTIFIER 29b. SIGNATURE AND TITLE OF CERTIFIER | HOSPITAL: 1 Department: 28s. OATE O (Month). 28s. PLACE building BICIAN: To the best of ER: HO COMPLETED CAL | □ ER/Outpatie F INJURY Day, Year) OF INJURY — p, etc. (Specify) of my knowledgexamination er | not resulting ent 3 □ DOA 28b. Till is At home, ferm, ge, death occur and/or investigat | OTHE 4 Nu ME OF JURY M street, fac | 28. PL R: rsing Home 28c. INJI Victory, office time, data opinion, d | ACE OF D 5 Ri URY AT RK? ES 2 [end place eath occu | NO NO | 28f. LOCify to the cattime, det | PERFOR 1 YES 2 ar (Specify) SCRIBE HOW I CATION (Street or Town, Stele) use(e) end mai | NJURY OC | CURED or or Rurel A | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |

| 7 / | bunial-transit permit. Pages 1, 2, 3 should | |
|--|---|--|
| BALTIMORE, MARYLAND 21203-3146 | arth. Page 6 may be retained by the hospital or attending uneral director, page 5 should be detached for use as the aminer must be notified at once. | |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2.1. nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

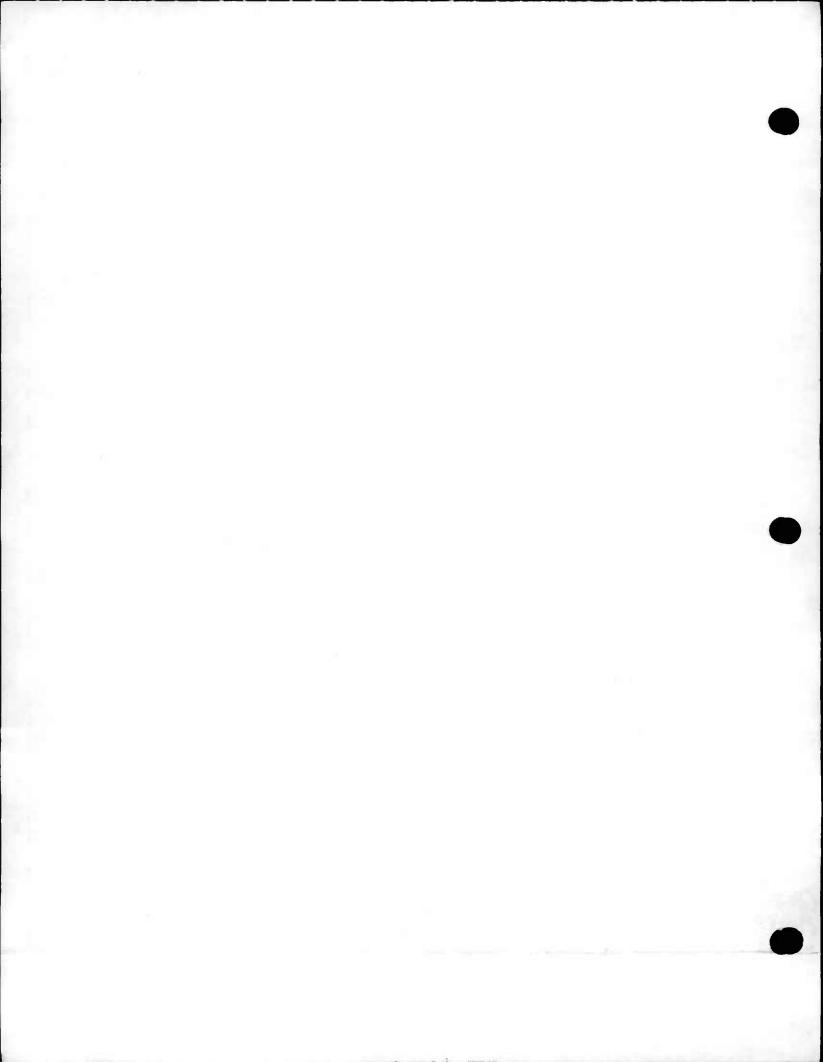
TO BE COMPLETED BY FUNERAL DIRECTOR

| FOR STATE | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL I | HYGIENE |
|--------------|---|----------|
| REGISTRAR | CERTIFICATE OF DEATH | REG. NO. |

| | REGISTRAR | | | ERTIF | ICATE | OF | DEAL | Н | RI | G. NO. | | | | |
|----------------------|--|--------------------------------|------------------------------|---------------------------------|--------------|-------------------|------------------|-------------|-----------------------------|-------------|-------------|--------------------|----------------|------------|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | | | | | | | | 2. DATE OF D | EATH | | | 3. TIME OF D | EATH |
| - 1 | Robert Elg | io | UTON | C | | | | | MONTH | DAY | 7 7 7 | PAR | 0 4 | 10. H |
| | 4. SOCIAL SECURITY NUMBER | | HICK | | | | | | Decem | | _12 | .199 | | 10p M |
| | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. | | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | 7. DATE OF B (Month, Day | | | 8. BIRTH Countr | PLACE (State o | or Foreign |
| | 160 12 4408 | 1 X M 2 F | | 71 YRS. | WON1INS | DATE | HOURS | MIN. | 02/04 | | | Joat | W | |
| | 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY | TOWN | OR LOCATIO | N OF DE | | 17 | 9c. COH | NTY OF D | Virgi: | 1113 |
| œ | The second secon | | | | 3. | | | | | | | | | |
| ō | Franklin Square 1 | Hospital | | | I | Ross | ville | 212 | 237 | | Balt | timo | re Co | unty |
| 2 | RESIDENCE OF DECEDENT | | | | | | | | | | | | | |
| # | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN O | R LOCA | ION | | | | | | 10d. INSIDE C | PITY |
| 0 | Maryland Baltin | nore Coun | t.v | Mi | ddle | Riv | er | | | | | | 1 YES 2 | W NO |
| ا بـ | 10e. STREET AND NUMBER | | | | 3020 | | . ZIP CODE | | | | 10g. CIT | IZEN OF V | VHAT COUNTRY | Y7 |
| FUNERAL DIRECTOR | 2510 P 17: T | | | | | | | | | | | | | |
| 뿔ㅣ | 3518 Dahlia Lane | | | | | | 1220 | | | 1 | | U. | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. | ARMED | 13. 1 | WAS DEC | ENDENT O | F HISPAN | IC ORIGIN? (Sp | ecity Yes | or No- | 14. RACI | — American I | Indien, |
| | 1 Never Married 2 Married | IF YES, GIVE W | OR DATES | | | | 2 XNO | | | . 010.) | ŀ | Spec | | |
| B | 3 Widowed 4 Divorced | World | War 2 | | - 1 | | $\Lambda\Lambda$ | | | | - 1 | - | White | |
| | 15. DECEDENT'S EDUC | | 16a. | DECEDENT'S | USUAL O | CCUPATIO | ON | | 16b. KIN | OF BUS | INESS/IND | OUSTRY | MILLE | |
| ΕI | (Specify only highest grade | | | (Give kind of life, Do NOT u | work done o | during mo | st of workin | g | | | | | | 1 |
| ا ت | Elementery/Secondary (0-12) | College (1-4 or 5 + |) | | | | | | | | | | | |
| 2 | 6 | | Fo | rk Li | Et Or | era | tor | | Foo | od Si | tore | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | _ | | 18. MOTH | IER'S NAI | AE (First, Middle | , Maiden : | Surname) | | | |
| | James Hicks | | | | | | | Lil] | lie ' | ? | | | | |
| H | 19a. INFORMANT'S NAME (Type/Print) | | | 105 MAIL INC | ADDRESS | 2 /Street | and Mumber | | loute Number, C | the or Town | Cteto 7/ | Codel | | |
| 2 | | | | | | | | | | | | | | |
| | Terry Hicks | | | 2802 1 | Vest | Fra | <u>nklir</u> | rvil | <u>Le Roac</u> | | | | 1d. 210 | 085 |
| - 1 | 20e. METHOD OF DISPOSITION 1 □ Buriel 2 □ Cremetion 3 □ Reme | ound from State | 20b. PLAC | E OF DISPO | SITION (Na | me of ce | metery, crem | atory or | | 20c. LO | CATION - | City or To | wn, State | |
| | 4 Donation 5 Other (Specify) | oval Irolli State | | y Hil | Mem | ori | al Ca | rdor | 10 | RATE | TMOI | DE C | ounty. | Ma |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | зэрнас | | 4 | | | ND ADDRES | | | DALL | | CE C | Juilly , | MU |
| | | | 1 . | / | Br | uzd | zinsk | i Fı | neral | Home | P . A | Δ . | 21221 | 1 |
| | Hans ! | 2nd | ney | 20 | | | | | | | | | Marylar | |
| | 23. PART / Enter the diseases, or o | complications that | catead the | deeth Do | not enter | the mo | de of dui | ng eucl | an cardiac | or recoi | retory or | net i | Approx | |
| | shock, or haert fellure. | List only one cau | se on each il | na. | not onto | are me | da or ayı | ing, auci | i de carato | or reap. | atory of | roet, | | al Batwean |
| | IMMEDIATE CAUSE (Finel | 1 222 | | | | | | | | Onset | and Deeth | | | |
| - 1 | disesse or condition resulting in death) | . Metast | atic | Carci | nom. | a o | f th | e h | еад а | nd . | neck | - | - | |
| | reacting in death) | OUE TO | OR AS A CON | SEQUENCE O | F): | <u>u</u> <u>u</u> | | | caa a | 114 | ii.c.c. | | | |
| _1 | _ | | | | | | | | | | | | | |
| 6 | Sequentially list conditions, | b | OR AS A CONS | REQUENCE O | . | | | | | | | | - | |
| E | if any, leading to immediate cause. Enter UNDERLYING | 502.10 | (OII AD A COIN | SECOLINOL C | . , . | | | | | | | | i | |
| 3 | CAUSE (Disease or injury | с | | | | | | | | | | | - | |
| <u>E</u> | that initiated events | DUE TO | OR AS A CONS | SEOUENCE O | F): | | | | | | | | | |
| E | resulting in death) LAST | d. | | | | | | | | | | | | |
| EDICAL CERTIFICATION | | | | | | | | | | | | | | |
| 7 | PART ii. Other aignificant condition | s contributing to | death but no | t resulting | in the ur | ndartyin | g cause g | given in | Part i. 24e | . WAS AN | AUTOPSY | 248 | . WERE AUTOPS | |
| 2 | Perforation o | f the J | einnn | m . | | | | | | YES 2 | | | COMPLETION | |
| | | | -June | | | | | • | - '' | TES Z | AT NO | | OF DEATH? | |
| Ξ | | | | | | | | | _ | | | | 1 YES 2 | □ NO |
| ż | | | | | | | | | | | | | | |
| × | 25. WAS CASE REFERRED TO MEDICAL | | | | | 28. P | LACE OF D | EATH (Ch | eck only one) | | | | | |
| 2 | EXAMINER? | HOSPITAL: | FR/Outpatient | 3 [] DOA | OTHE | | 00 5 T B | oldonoo | 6 Other (Sp | and a | | | | |
| PHYSICIAN: | 27. MANNER OF DEATH | 26a. DATE OF | | 28b. TIR | | | JURY AT | I | 28d. OESCRII | | HILBY OC | CUBED | | |
| | 1X Natural 5 Pending | (Month, D | ay, Year) | IN. | JURY | W | DRK? | | zou. Ocaonii | E HOW I | NJOHT OC | CUNED | | - 1 |
| ВУ | 2 Accident Investigation | | | | | 1 📙 | YES 2 | NO | | | | | | |
| | 3 Suicide 6 Could not be | 28e. PLACE O | F INJURY — At etc. (Specify) | home, ferm, | street, fact | lory, offic | :0 | | 26f. LOCATIO City or To | | ind Numbe | r or Rural | Route Number, | |
| COMPLETED | 4 Homicide determined | - Consump | eta (opocny) | | | | | | City of 10 | wn, State) | | | | |
| m | 290. CERTIFIER | | | | - | | | | | | _ | | | |
| 립 | (Check only | CIAN: To Ihe best of | my knowledge, | death occur | red at the t | ilme, det | and place | , and due | to the cause(s |) and mar | nner sa ste | rted. | | |
| 3 | one) 2 MEDICAL EXAMINE | R: On the basis of ex | camination and/ | or investigati | on, in my o | opinion, | death occur | red at the | lime, data and | place, an | d due jo j | he cause | a) and manner | as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | | 00-110 | FA10F A1111 | 1050 | _ | 201 20 | | | |
| BE | 296. SIGNA OF EARD TITLE OF CERTIFIE | 00- | 0 | 0 | | | 29c. LICI | ENSE NUA | MBER | | 29d, DA | E SIGNE | (Month, Day, 1 | 7 7 |
| | Machin | you | Me | cy | | | | N/ | A | | | 2/ | 12/1 | 70 |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUS | SE OF DEATH (| TEM 27) (Typ | e, Print) | | | | | | | 7 | 1 | |
| | Madhu Chaudry, | M D QO | በበ ፑፖ | ankli | n c | CHE | re r |)r | Ra1+i | mor. | о Мт |)) | 1227 | |
| | 31. DATE FILED (Month, Day, Year) | M.D. 90 32 REGISTRA Julia Da | R'S SIGNATUR | E CITY T | 11 5 | yua | TE L | · L • | Daltl | TIOT | e M | , 2 | 143/. | |
| | DEC 1 4 1990 | 10 K | المسمالين | andell | | | | | | | | | | |
| | | 1 | AFTERNATION OF | | | | | | | | | | | |



DHMH-18 Rev 1/89



BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within.

TO THE FUNERAL DIRECTIOR: After this certificate has been signed by the attending physician and completely fire in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL | HYGIENE REG. NO. |
|--------------------------------------|---|-----------|---------------------|
| ECEDENT'S NAME (First, Middle, Last) | | 2. DATE O | F DEATH |

| REGISTRAR | CERTIFIC | CATE OF DEATH | REG. NO. | |
|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Lest) | on With | | 2. DATE OF DEATH MONTH DAY | YEAR 249 P. |
| 4. SOCIAL SECURITY NUMBER 212-27-2097 | 8. SEX 6. AGE (In yrs. last birthday) | F UNDER 1 YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign Country) Mary hard |
| 9a. FACILITY NAME (If not institution, give str MH HAGE RESIDENCE OF DECEDENT | ook and number 9 | b. CITY, TOWN OR LOCATION OF D | EATH 9c. CO | UNTY OF DEATH |
| 10e. STATE 10b. COUNTY | 10c. CITY, | Balto, | | 16d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 1411 E Eag | ier Street | 101. ZIP CODE 2/20 | 5 | TIZEN OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. APMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 140 Speci | | 14. RACE — American Indian, Black, White, etc. Specify: Black |
| 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12) | | k done during most of working | 186. KIND OF BUSINESS/IN | IDUSTRY |
| 17. FATHER'S NAME (First, Middle, Last) | te | TIAU | AME (First, Middle, Maiden Signame) NYA Oak | enes |
| 19e. INFORMANT'S NAME (No. Print) | er 196. MAILING AI | DORESS (Street and Number or Rural) | 21 4 | 21205 |
| 20a. METHOD OF DISPOSITION 1 Burlal 2 Operation 3 Remo 4 Donation 6 Other (Specify) | visi from State offer place) \(\sqrt{2} \sqrt{2} \sqrt{2} \sqrt{2} \qqrt{2} 2 | ION (Name of company, commellory or | 20c. LOCATION | exille Md |
| 21. SIGNATURE OF FUNERAL SERVICE ME | Side | Jeff M. [| En F/4 18 | 39 NASKALU 21213 |
| 23. PART I. Enter the disease, or conshops, or heart failure. I. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | omplications that caused the death. Do not let only one cause on each line. a | t anter the mode of dying, sur | ch as cardido or respiretory a | rrest, Approximeta Interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | BRONUNO A | MNUNC LB | |
| POUN'S | contributing to death but not resulting in SYNDPOMC | the underlying ceuse given in | 24a. WAS AN AUTOPS' PERFORMED? 1 YES 2 NO | 24b, WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 MO |
| 25. WAS CASE REFERRED TO MEDICAL | PHALUS | 26. PLACE OF DEATH (C | heck only one) | |
| EXAMINER? 1 YES 2 NO | | OTHER: | | |
| 27. MANNED-OF DEATH 1 Netural 8 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME (INJUR | | 28d, DESCRIBE HOW INJURY OF | CCURED |
| 3 Suicide 8 Could not be 4 Homicide determined | 28s. PLACE OF INJURY — At home, term, atro- building, atc. (Specify) | eet, factory, office | 28f. LOCATION (Street and Numb City or Town, State) | er or Rutal Route Number, |
| | CIAN: To the best of my knowledge, death occurred a: On the best of examination and/or investigation, | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | The state of the s | 29c. LICENSE NU | MBER 29d. DA | TE SIGNED (Month, Day, Year) |
| System of the state of the stat | COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P. | 1708 W | Robbles | BALTI MO |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | |

B - 1 - 2 - 1 - 1

TO BE COMPLETED BY FUNERAL DIRECTOR

| BALTIMORE, MARYLAND 21203-3146 | are after death. Page 6 may be retained by the hospital or attending physical | don by the funeral director, page 5 should be detached for use as the buna | I, OF IEMOVAL. | e medical examiner must be notified at once. |
|--|--|---|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within? 🚜 after death. Page 6 may be retained by the hospital or attending physic | THE FINERAL ONECTOR: After this certificate has been signed by the attending physician and complete. At the funeral director, page 5 should be detached for use as the burian | ithin 72 hours after death with the State Dept. of Health and Mental Hygliene prior to bunds, cremation, or removal, | defrant; if tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

Sequentially list conditiona, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury

that initiated events reaulting in death) LAST

| | | | | | | | | | | | | | 91 | 342 | 37 |
|--|-------------------|--------------------------------|---------------------------------------|------------|----------------------------|----------------------|----------------------|-------------------------|------------|-----------------|-------------------------------|-------------|-------------|---------------------------------------|--------|
| 1 - STATE REGISTRAR | | STATE OF M | IARYL | | / DEPAR ERTIF | | | | | MENTA | L HYGIEN REG. NO. | E | 50 | 0 1 1 | |
| 1. DECEDENT'S NAME (First, | Middle (net) | | | | 4 | 10/1 | 1 - 01 | סבת | | 2 DAT | E OF DEATH | | | 3. TIME OF DEATH | |
| | | Monan | | | | _ | | | | MON | | W | 90 | 4:15P | |
| Charlot | | Morgan | | | . Cha | | | 1 | | | | | _ | | М |
| 4. SOCIAL SECURITY NUME | BER | 5. SEX | 6. AGE (| in yrs. le | st birthday) | MONT | DER 1 YEAR | HOURA | 24 HRS. | 7. OATE (Mon | E OF BIRTH hth, Day, Year) | | 8. BiRTI | HPLACE (State or Fore try) | eign - |
| 213 46 4753 | | 1 - M 2 - F | | 84 | YRS. | mon. | na berra | noona | | 10 | /06/06 | | Ba1 | timore. M | /ld |
| 90. FACILITY NAME (If not in | stitution, give : | street and number) | | | | 9b. C | CITY, TOWN | OR LOCATI | ON OF DI | EATH | | 9c. CO | UNTY OF D | | |
| Dulaney-Town | son Nu | rsing Hor | 1e | | | To | owson | 2 | 1204 | <u>,</u> | | Bal: | timor | e County | |
| RESIDENCE OF DEC | 10b. COUNT | | | | 100 000 | v TOM | VN OR LOCA | TION | | | | | | 10d. INSIDE CITY | |
| Maryland | | .more Cou | nty | | | WSC | | IION | | | | | | LIMITS? | NO |
| 10e. STREET AND NUMBER | | | | | | | 10 | H. ZIP COD | E | | - | 10g. CI | ITIZEN OF | WHAT COUNTRY? | |
| 111 West Ro | ad | | | | | | | 2120 | 4 | | | | U.S | S.A. | |
| 11. MARITAL STATUS | | 12. WAS DECEDEN | | | | Т | | | | | IN? (Specify Yes | or No- | 14. RAC | E — American Indias k, White, etc. | n, |
| 1 Never Merried 2 | Merried | FORCES? 1 | | | INO | | | pecify Cube S 2 🙀 NO | | | Rican, atc.) | | Spec | | |
| 3 🔀 Widowed 4 🗌 Divo | proed | | , , , , , , , , , , , , , , , , , , , | 7.7 | | | X | | | | | | White | | |
| | EDENT'S EDU | | | 16a. D | ECEDENT'S | USUA | L OCCUPAT | ION | | 16 | b. KIND OF BU | SINESS/II | NDUSTRY | | |
| (Specify only Elamentery/Secondary (0 | y highest grade | completed) College (1-4 or 5 + | - | in | Give kind of the Do NOT us | work di sa retire | one during n ed.) | ost of worki | ng | | | | | | |
| 1.0 | , , | College (I-4 8) 5 4 | ' | | Hous | ousewife HOME | | | | | | | | | |
| 17. FATHER'S NAME (First, M | liddle (ast) | | | | | | | 18 MOT | HER'S NA | MF /First | Middle, Maiden | Sumama |) | | |
| | lfende | en | | | | | | | a Pa | , , | | 00.714.110) | , | | |
| 190. INFORMANT'S NAME (7 | Type/Print) | | | 1 | 96. MAILING | ADDE | RESS (Street | and Numbe | r or Rural | Route Nu | mber, City or Tow | n, State, | Zip Code) | 2070 | 1 |
| Robert Hawle | еу | | | 1 | .503 V | Vi1 | 1age | Drive | ∋ Ар | t. 4 | Wilin | gton | Nor | th Carol | ina |
| 20e. METHOD OF DISPOSIT | | | 20b | other i | E OF DISPO | SITION | (Name of c | emetery, crea | matory or | | 20c. LC | CATION - | — City or 1 | lown, State | |
| 4 Donation 5 Other | | noval from State | - Dr | | Ridg | ge | Cemet | ery | | | Ba1 | timo | re M | aryland | |
| 21. SIGNATURE OF FUNERA | L SERVICE LI | CENSEE | | 1 | | | 22. NAME | | | | | | | | |
| N | 0 | // | - 1 | | | E | 3ruzd | zinsk | i Fu | ınera | al Home | P. | Α. | 21221 | |
| Man | 13 | man | 110 | | | | 1407 | 01d E | aste | ern / | Ave Bal | Ltime | ore M | <u>laryland</u> | |
| 23. PART I. Enter the d | | complications that | | | | not e | nter the m | ode of dy | ing, aud | ch aa ca | rdiac or reap | Iratory a | arreat, | Approxima Interval Be | tween |
| IMMEDIATE CAUSE (FI | nal | 0 | 0- | | () | , ~ | 1 | | ra. | | . + | | | Onset and | Death |
| disease or condition | → | · Ca | relle | 0-1 | WI) | AN | 1911 | W | W | VU | 4 | | | ļ | |
| July 11 double | | DUE TO | OR AS | CONS | EOUENCE | F): | , | 1 | -1 | 1 | | | | | |
| | | | 1/1 | 91 | On te | u D | 101 | 211 | La | ILU | 10 | | | | |
| Sequentially list condit | | DUE TO | (OR AS | CONS | EQUENCE O | F): | | V | 1 | | | | | | |
| If any, leading to imme | ruidle. | | 1 - | T. | | | | | P | | | | | | |

PART ii. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i.

DUE TO (OF AS A CONSEQUENCE OF):

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 - YES 2 NO OF DEATH? 1 TES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | ER/Oulpatient 3 | DOA 1 YES 2 NO Nursing Home 5 - Residence 8 - Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 1 YES 2 NO 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be determined 4 Homicide

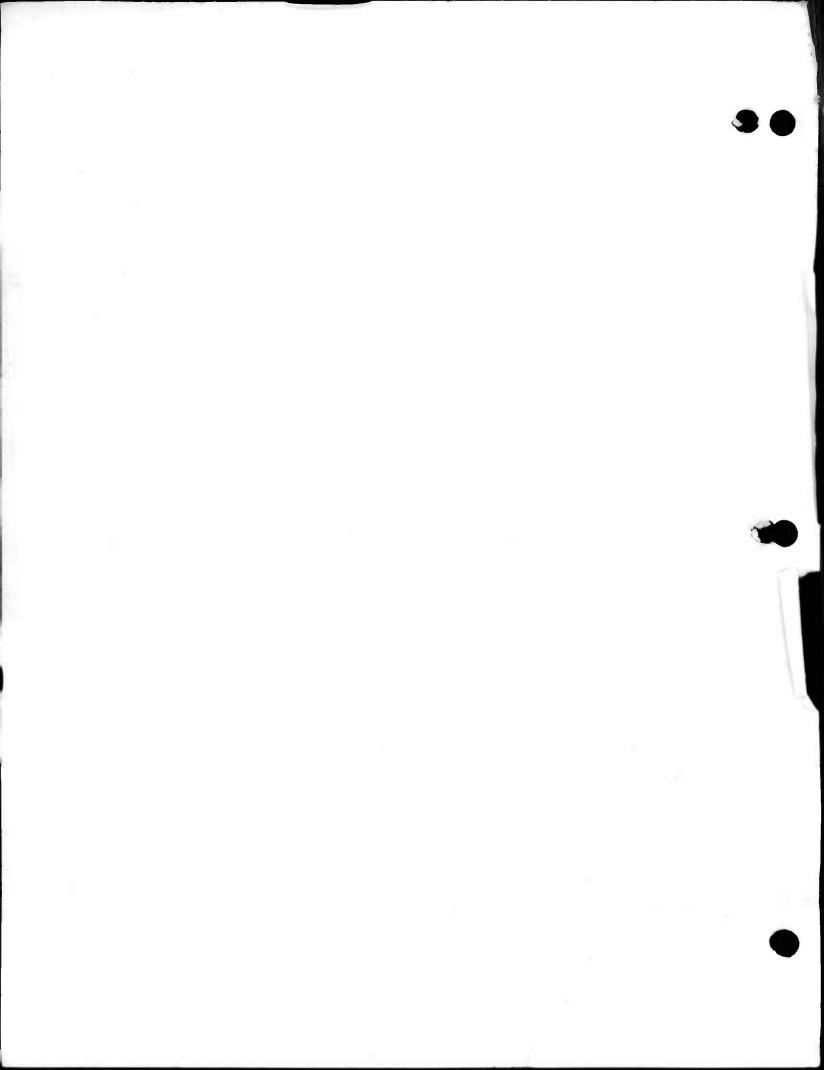
| 29e. CERTIFIER | 1 💢 | CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(e) end menner se stated. |
|----------------|-----|--|
| one) | 26 | MEDICAL EVALUATED. On the heels of exemination and/or imperioration in my coloins death occurred at the time date and place and due to the cause |

296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER
1) -14618 29d. DATE SIGNED (Month, Day, Year)

| Jamay, M | W. att. Phys 40 | in 1)-14618 | 12/11/96 |
|---------------------------------------|---|----------------------|-----------------|
| 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE OF DEATH (ITEM 27) (Type, / | rint) | |
| BIENVENIDU F | 1-MATOS- 21 | CRANBROOK Rd COLKEYS | VILLE, M. 2/09, |
| 21 DATE Ell ED (Month Day Year) | 32 REGISTRAR'S SIGNATURE | | 7 |

Luka Davidson-Randall

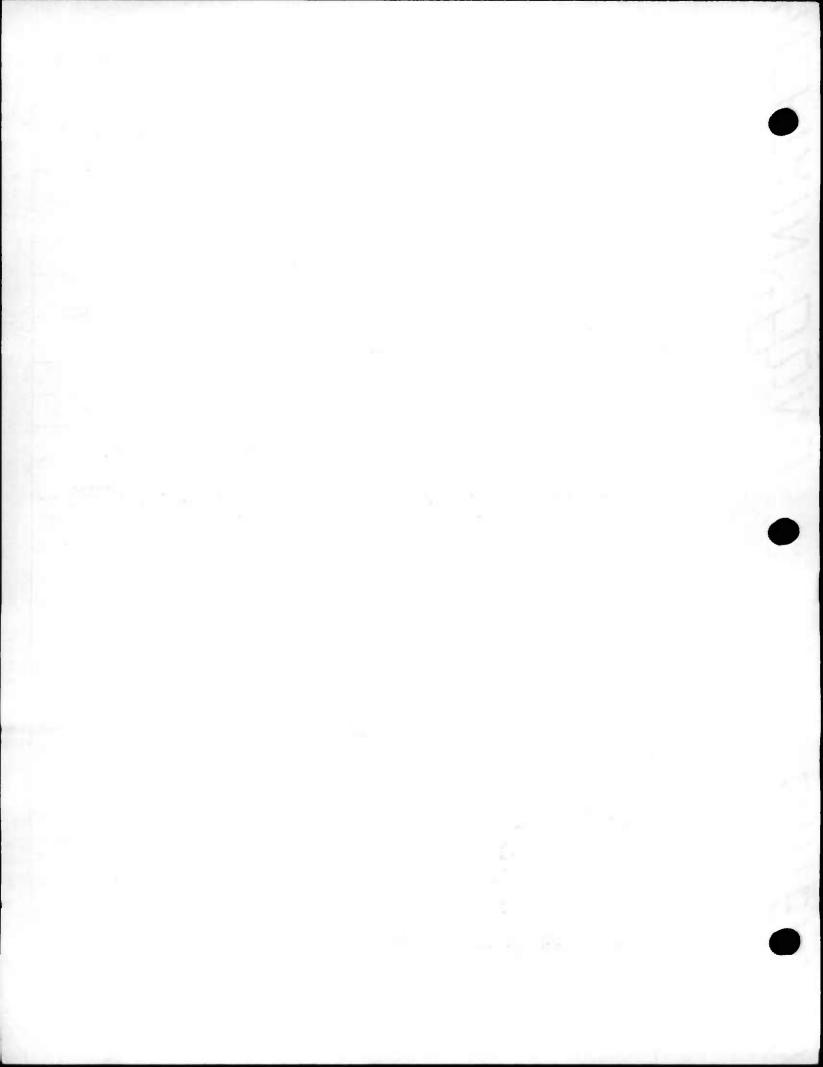
DHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21203-3446 | rysician: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending or account. | od in by the funeral director, page 5 should be detached for use as the memeric permit. Pages 1, 2, 3 should or removal. | medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 in | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the smaller set bermit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Debt, of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| j | FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL HYGI | | |
|---|--|--|--|------------------------------|--------------------------------|--|-----------------------------|--|
| 1 | 1. DECEDENT'S NAME (Bust, Middle, Lest) | HOOD | | | | 2. DATE OF DEATH | 16 | SAR 1220P M |
| | 4. SOCIAL SECURITY NUMBER 2 1 2 - 10 - 06 78 | 5. SEX 6. AGE (In | 8 YRS. | F UNDER 1 YEAR ONTHE DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIFTH (Month, Day, Year VOV 9 | 160 | BIRTHPLACE (State or Foreign Country) 1ARYLAND |
| E I | 9a. FACILITY NAME (If not institution, give si VILLA ST. MICH | SHOW - West- | 91 | | LTIMORE | ATH | 9c. COUNTY | OF DEATH |
| ב | RESIDENCE OF DECEDENT | | | | ur em secultura es | | | |
| DIRECTOR | MARYLAND 106. COUNTY | | 10c. CTTY, 1 | BALTT | | | | 10d. INSIDE CITY LIMITS? 1 Y YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | 0 | | 101 | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| NE. | 11. MARITAL STATUS | 3 RECTORY LAN | | 13. WAS DEC | 21211 | IC ORIGIN? (Specify | Ves or No. 14 | USA RACE — American Indian, |
| à | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 TYES IF YES, GIVE WAR OR DAT | 2 TNO | If yes, sp | | n, Puerto Rican, etc. | | Black, White, etc. Specify: WHITE |
| | 15. OECEDENT'S EDUC (Specify only highest grade | | 16a. DECEOENT'S US (Give kind of work | k done during mo | | 16b. KINO OF | BUSINESS/INDUST | |
| COMPLETED | Elementary/Secondary (0-12) 8TH | College (1-4 or 5+) | HOUSEI | Eg. v | | | | |
| S | 17. FATHER'S NAME (First, Middle, Last) | | HOUSE | VILL | 16. MOTHER'S NAI | ME (First, Middle, Mai | den Surname) | |
| BEC | CHARLES MCCART | HY | | | STEL | LA KIRK | | |
| 2 | JUNE EVANS | | | | | TIMORE, | | |
| | 20e. METHOD OF OISPOSITION 1 Specific Burial 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | PLACE OF DISPOSITION OTHER PROCESS OF DISPOSITION O | | | | LOCATION — City ALTIMORE | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | ^ | 22. NAME AN | D ADDRESS OF FA | CILITY | | |
| | · U. ala | n Seita | Ja . | 3818 | ROLAND | Z, JR. F AVENUE, | BALTO., | MD. 21211 |
| | 23. PART I. Enter the diseases, or a shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. Acute 6 | elfline. Mys ca | | | | | Approximate Interval Between Onset and Death |
| NO. | Sequentially list conditions, | min a | CONSEQUENCE OF): | re 1 | heart | decea | -0 | |
| CERTIFICATION | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events | c. OUE TO (OR AS A | CONSEQUENCE OF): | | _ | | | |
| ËRT | resulting in death) LAST | d | | | | | | |
| SA | PART II. Other significant condition | s contributing to death bu | it not resulting in | the underlyin | j cause given in | PEF | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDI | | | | | | _ | | 1 TES 2 NO |
| ¥ | 25. WAS CASE REFERRED TO-MEDICAL | | | 26. PI | ACE OF DEATH (Ch | eck only one) | | |
| ၁၂ | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outpa | | THER! | | 6 Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Natural 8 Pending | 28a. OATE OF INJURY (Month/Day, Year) | 28b. TIME (| OF 28c. INJ | | 28d. DESCRIBE HO | W INJURY OCCUP | RED |
| 2 Accident investigation 28s. PLACE OF INJURY — at home farm stress factors define. | | | | | | | | Rural Route Number, |
| COMPLETED | onel | ICIAN: To the best of my knowle | | | | | | |
| BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE | al a 110 | 1000 | PUR | 29c, LICENSE NUI | MBER 2 | 29d. DATE 3 | IGNED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 0 - | TH (ITEM 27) (Type, P | rint) | -1+ | 212 | C- | - 12- 10 |
| | 31. DATE FILED (Month, Day, Year) | - 32, REGISTRAR'S SIGNA | TURE | c He | ghy | 2120 | 1 | |
| | | 191 Julia David | bon- Bindal | Ē | | | | |

OHMH-18 Rev 1/89



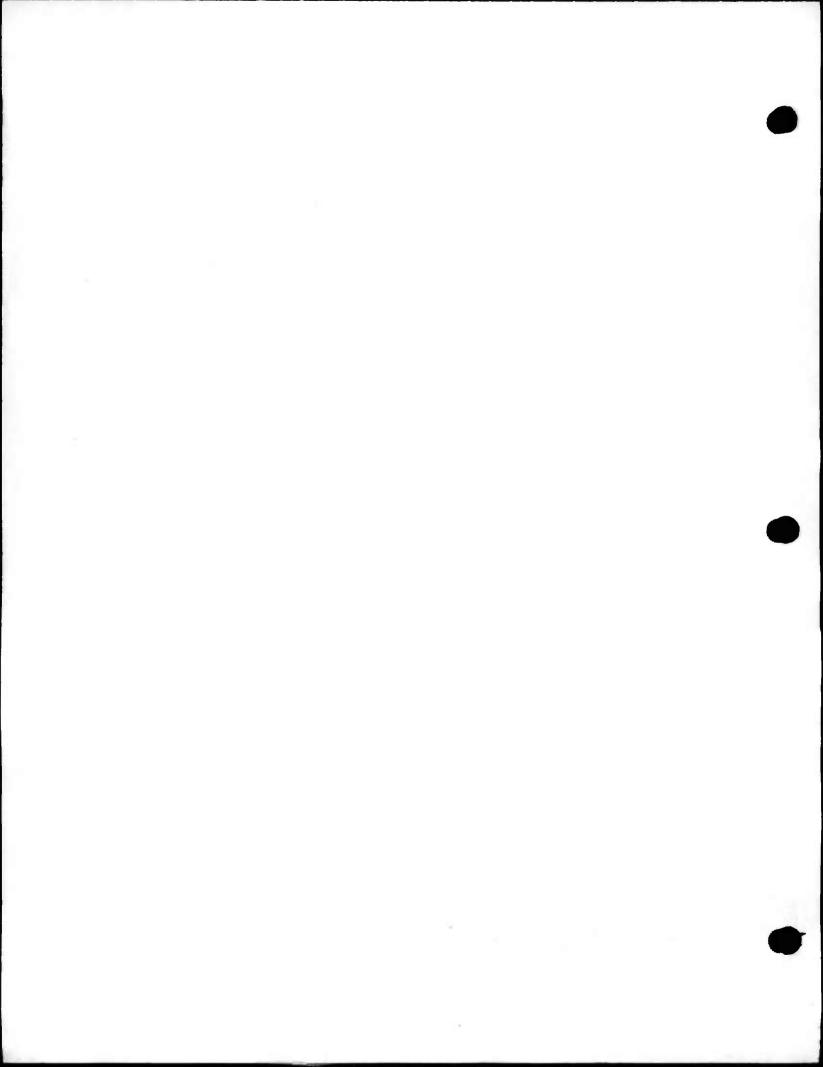
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| - | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I CERTIFICATE OF DEATH | MENTAL HYG REG. | |
|---|-----------------------------------|--|--------------------|-----|
| þ | ECEDENT'S NAME (First, Middle, L. | 1817 | 2. DATE OF DEAT | н |
| | Madda 1 | NUCON | MONTH | DAY |

| | REGISTRAR CERTI | FICATE OF DEATH | REG. NO. | |
|---------------|--|---|--|---|
| | 1. DECEMBRY'S NAME (First, Middle, Last) Mattie JOHN'SON | | | EAN 3. TIME OF DEATH |
| 1 | Mattie JOHNSON 4. SOCIAL SECURITY NUMBER S. SEX 8. AGE (In year birthda) | | The state of the s | 90 6:06 A |
| 1 | 011155 1/2 10 M2 OF 16 67 YRS | F UNDER 1 YEAR F UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | BIRTHPLACE (State or Foreign Country) |
| | THE PRICELETY MANUFACTOR and Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution of Institution | | 926, 188 | sentrour |
| l ac | The second of th | SE. CITY, TOWN OR LOCATION OF D | EATH - 96 COUNTY | OF DEATH |
| ΙĒ | HESIDENCE OF DECEDENT | 1 Rolling | re Rolt | imore |
| DIRECTOR | | TTY, TOWN OF LOCKTON | Daire | ADD INSIDE CITY |
| # | mx / C - A | Sallinge | morshow | LIMITE? |
| | 10s. STREET AND NUMBER | 101, ZIP CODE | 10g. CITUSE | N OF WHAT COUNTRY? |
| EB | 900 Calon luce | 2122 | 9 0/ | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | | | . RACE — American Indiag. |
| | 1 Never Married 2 Married FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yes, specify Cuban, Mexic 1 ☐ YES 2 ☐ NO Speci | | tigets, where, see |
| B | 3 Widowed 4 Divorced | | | BUCK |
| ED | | 'S USUAL OCCUPATION of work done during most of-working | 18b. KIND OF BUSINESS/INDUS | TRY |
| 19 | Elementary/Secondary (0-12) Collage (1-4 or 5+) | use retired.) | grene | > |
| AP . | Muching) unitra) 1 | infrage | | |
| COMPLET | 17. FATHER'S NAME (First Middle, Last) | 18. MOTHER'S N | AME (First, Middle, Maiden Sumame) | |
| 111 | anenous | un | freun | |
| TO BE | 19a, INFORMANT'S NAME (Type/Print) | NG ADDRESS (Street and Number or Rural | Route Number, City of Town State, Zip Co | ode) |
| - | Alive Ouverghe 3. | 313 Japa | or of | |
| | 20s. METHOD OF DISPOSITION 1 Durlay 2 Cremation 3 Removal from State office of DISP | OSITION (Name of cemetery, garnatory or | 20c, LOCATION — CIT | y fr Town, Stata |
| | 4/ Donation 5 Other (Specify) | - Semida | spile Poll | In |
| | 21. SIGNATURE OF PUNERAL SERVICE LICENSEE | 23. NAME AND ADDRESS OF F | ACILITY | Rolling |
| | Well To Cun | 2300 4 | 1 rething | 2511 |
| | 23. PART I. Enter the diseases, or complications that caused the death. D | not enter the mode of dving, su | ch as cardiac or respiratory error | t, Approximete |
| | shock, or heart fellure. List only and cause on each line. | not onto the mode of dying, so | on as cardiac or respiratory erres | Interval Betw |
| | IMMEDIATE CAUSE (Fine) disease or condition Urosepsis Pneumo: | sensis | | Onset and D |
| | resulting in desth) s | | | |
| | _ Renal Failure | 5. p | | İ |
| CERTIFICATION | Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE | OF): | | |
| M | If any, leading to immediate cause. Enter UNDERLYING | | | |
| F | CAUSE (Disesse or injury that initiated events DUE TO (OR AS A CONSEQUENCE | OF): | | |
| F | resulting in death) LAST | | | |
| | | | | |
| DICAL | PART II. Other significent conditions contributing to death but not resulting | g in the underlying cause given in | Part i. 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDS AVAILABLE PRIOR TO |
| DIC | Severe Grade III Lef∓ Hip Ulcer | | 1 [] YES 2 [X] NO | OF DEATH? |
| . WE | | | | 1 TYES 2 NO |
| ä | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 28. PLACE OF OEATH (C | theck anly one) | |
| YSI | 1 TYES 2 NO 11 Inpatient 2 ER/Outpetient 3 DO/ | | 6 Other (Specify) | |
| 표 | (Month, Day, Year) | TIME OF 28c. INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OCCU | RED |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | M 1 YES 2 NO | | |
| | 3 Suicida s Could not be 28s. PLACE OF INJURY — A1 home, fan building, etc. (Specify) | n, atreet, factory, offica | 28f. LOCATION (Street and Number or City or Town, State) | Rural Route Number, |
| H | 4 Homicide detarmined | | | |
| COMPLETE | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occ | urred at the 1lms, data and place, and du | a to the cause(a) and manner as stated | |
| 8 | one) 2 MEDICAL EXAMINER: On the basis of examination and/or investig | | | |
| | 285. SIGNATURE AND TITLE OF CERTIFIER | 29c. LIQENSE NU | | BIGNED (Month, Day, Year) |
| BE | March / the Do | 17 6 | 05/25 11 | 13/20 |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (7) | rpe. Print) | -00 10 | 1.011 |
| 유 | | r · · · · · · · · · · · · · · · · · · | | |
| 2 | | anklin So Do | 01007 | |
| 5 | Marc Westle, M.D. 9000 Fr | anklin Sq. Dr., I | Balto. 21237 | |
| 1 | | anklin Sq. Dr., I | Balto. 21237 | |





BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| ge 6 may be retained by the hospital or attending physician. | frector, page 5 should be detached for use as the burial-transit permit. Pages 1, | | r must be notified at once. |
|---|--|---|--|
| HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 🗠 nours after death. Page 6 may be retained by the hospital or attending physician. | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, | within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | ITANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

2, 3 should

90 34240 FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Joe Jennings 12-10-90 Ellis 7:40PM 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER t YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Foreign 248-34-1 M 2 F YAS 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 762 Poplar Grove Street Baltimore City DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c, CITY, TOWN OR LOCATIO 10d. INSIDE CITY 1 TES 2 | NO BY FUNERAL 100. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yes, specify Cuber, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMER FORCES? 1 YES 2 LINO 14. RACE Black 1 Never Married Black IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY 1215A 16. MOTHER'S NAME (First, Middle, Majden Sums BE 19b. MAILING ADDRESS (St 2 NETHOD OF DISPOSITION
Burial 2 Cremation 3 20b. PLACE OF DISPOSITION 4 Donation 6 Other (Specify) FUNERAL SERVICE 22. NAME AND ADDRESS OF FACILITY 2/21 Se Nesc complications that caused the deeth. Do not enter the mode of dying, such as cerdied or respiratory errest, Approximate ahock, or heart fallure. List only one cause on each line intervai Between IMMEDIATE CAUSE (Final Onset and Death disease or condition Arteriosclerotic cardiovascular disease reaulting in desth) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reaulting in death) LAST marked, or Item 23 shows any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 246. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL AVAILABLE PRIOR TO COMPLETION DF CAUSE Diabetes Mellitus YES 2 | NO OF DEATH?

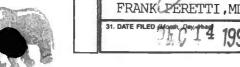
| | | | XX YES 2 NO | | | | | | |
|--|--|---------------------------------------|---|--|--|--|--|--|--|
| 5. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C | heck only one) | | | | | | |
| | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DO/ | OTHER: 4 Nursing Home 5 Residence | Home 5, Residence 8 Other (Specify) | | | | | | |
| 77. MANNER OF DEATH 12 Accident Investigation | | TIME OF INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | | | |
| 3 Suicide 6 Could not be determined | 26a. PLACE OF INJURY — At home, fami building, stc. (Specify) | m, street, factory, offica | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and menner as stated. 29

| L SIGNATURE AND TITLE OF CONTIFIER | 29c. LICENSE NUMBER | 29d. DATE SIGNED (Month, Day, Year) |
|---|---------------------|-------------------------------------|
| LUVII | OCME | ▶ 12-11-90 |
| NAME AND ASSURED OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Time | Delect | |

36.

| MANAGERETIT, MD | 111 | Penn | Street, Baltimore, MD | 2120. |
|------------------|-----|------|-----------------------|-------|
| RANK PÉRETTI, MD | 111 | D | Olevert Dell' am | 0400 |



BY 99 L DIRECTOR: A

COMPLETED

BE 2

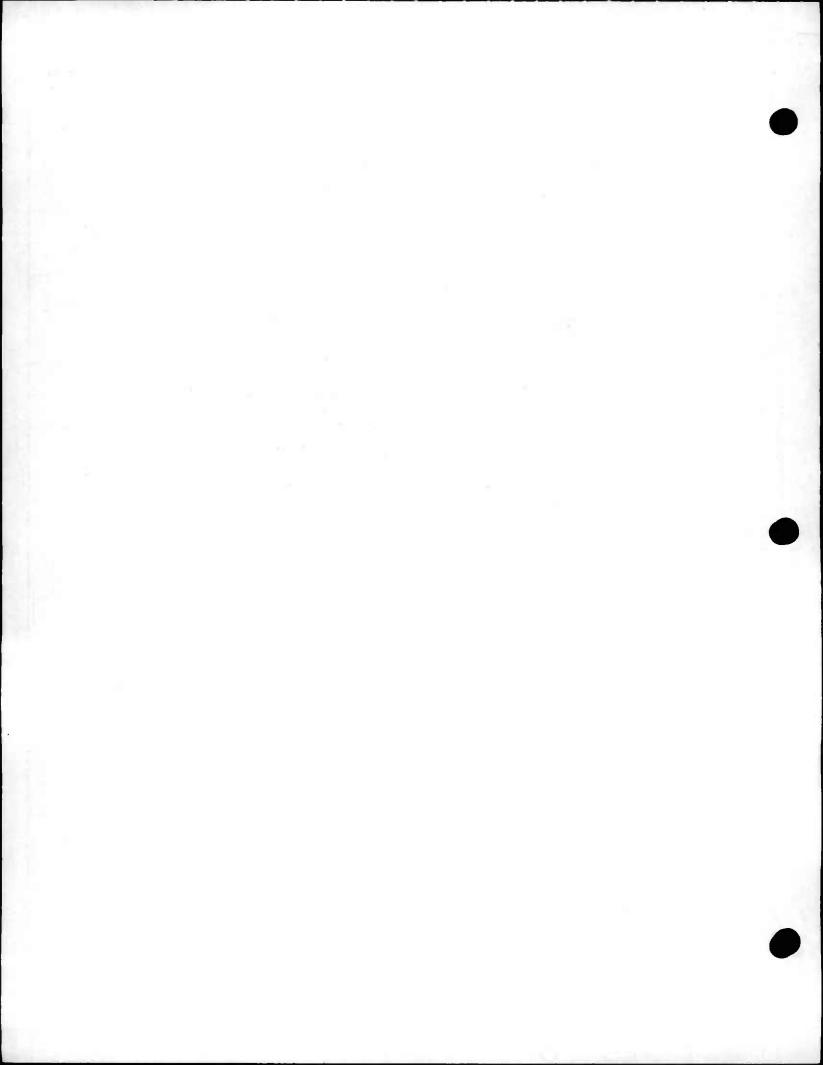
TO THE HOSPITAL OR ATTENC TO THE FUNERAL DIRECTOR: be filed within 72 hours after IMPORTANT: If Item 28 is

ha Devidso

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VC





ansit permit. Pages 1, 2, 3 should TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital if IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

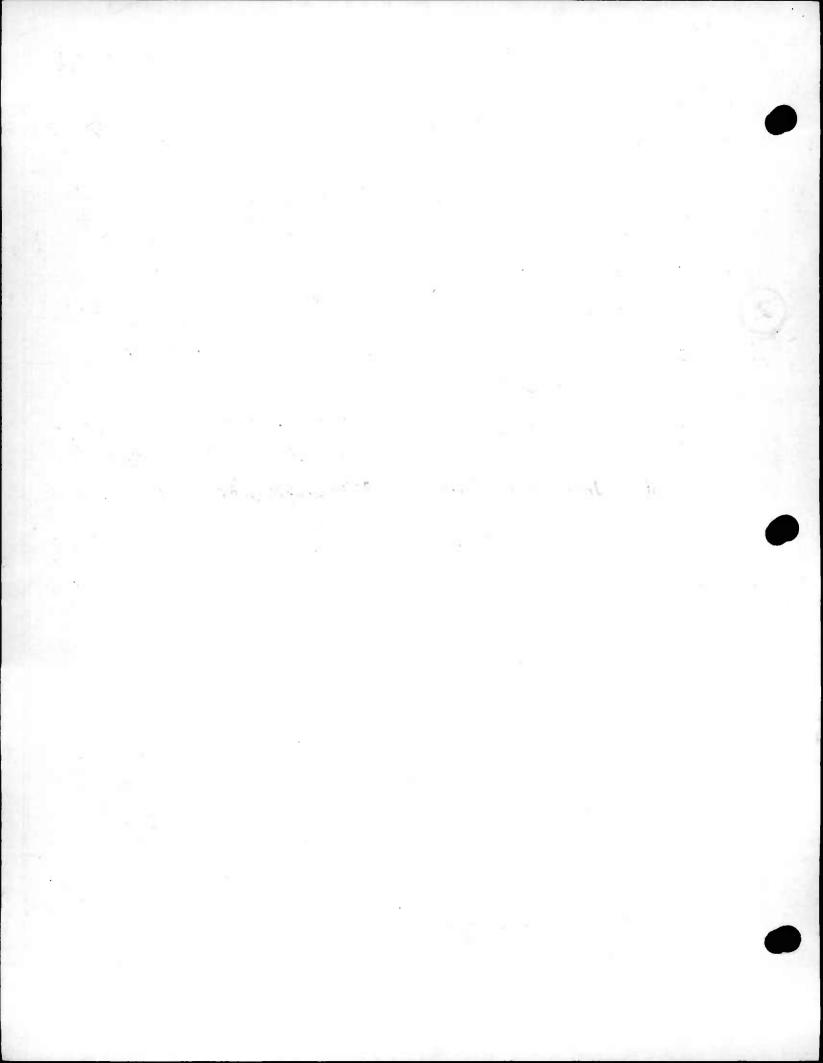
BALTIMORE, MARYLAND 21

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH
REG. NO.

| | REGISTRAR | | CERTIFICA | TE OF DEATH | REG. N | 0. | | | | | |
|---------------|---|---|---|--|--|--------------------------|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Johnson | 1.01 | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH | | | | |
| | 214 30 54071 | MM2 OF 5 | C YRS. MONTH | | 7. DATE OF BIRTH (Month, Day, Year) 3/3/34 | | BIRTHPLACE (State or Foreign Country) | | | | |
| CTOR | 98. FACILITY NAME (If not institution, give street 1019 MISTY L., Y RESIDENCE OF DECEPENT | NN Circle | 9b. C | OCKEYS VI | 1 e | Balle Balle | or County mg | | | | |
| L DIRECTOR | 10a. STATE 10b. COUNTY M d Bala 10b. STREET AND NUMBER | 5- | 10c. CITY, TOW | N OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | | | | |
| FUNERAL | 1019 MISTX | LYNN C | itcle | 101. ZIP CODE 2 1030 3. WAS DECENDENT OF HISPA | NIC ODICINO (P | U. | N OF WHAT COUNTRY? | | | | |
| ВУ | 1 Never Married 2 Married 3 Widowed 4 Divorced | | ON | If yee, specify Cuben, Maxico | an, Puerto Rican, atc.) | THE OF NO. | I. RACE — American Indian, Black, Whita, atc. Specify: BLtiCK | | | | |
| COMPLETED | e / n. | ION npleted) College (1-4 or 5+) | (Give kind of work do life. Do NOT use retire | ne during most of working d.) | 4 | USINESS/INDUS | | | | | |
| NO | 17. FATHER'S NAME (First, Middle, Last) | | i | | ME (First, Middle, Maid | | , | | | | |
| BE | HARRY N. JOI | NEON W | 1 | Louis | | lea | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | N 811 | 3570 LA | SS (Street and Number or Rural | Route Number, City or The | own, State, Zip Co | ode) | | | | |
| | 20a. METHOD OF DISPOSITION 1 Surfal 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | 20b, F | | (Name of cemetery, crematory or | 10 | LOCATION — Cit | y or Town, State | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIFEN | Erko Jul | | 2. NAME AND ADDRESS OF FA | NCILITY NEW TOME | 1304 m | 6. 100 | | | | |
| | 23. PART I. Enter the oiseeses, or come shock, or heart failure. List IMMEDIATE CAUSE (Finel disease or condition resulting in death) | t only one couse on sec | Monser | is ASV | ardiec or res | piratory arres | t, Approximate Interval Between Operat and Death | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury ca. | | | | | | | | | | |
| CERTIF | that initiated events resulting in death) LAST d. | | | | | | | | | | |
| | PART II. Other aignificant conditions c | ontributing to death but | not resulting in the | underlying cause given in | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO | | | | |
| : MEDICAL | | | | | 1 YES | 2 [] NO | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | |
| PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINERY | | | 28. PLACE OF DEATH (G) | Teck only one) | | | | | | |
| YSI | TES 2 NO 1 | OSPITAL: Inpetient 2 ER/Outpet | lent 3 DOA 4 DI | ER: lursing Home 54 Residence | 6 Other (Specify) | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOV | V INJURY OCCU | RED | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 26e. PLACE OF INJURY – building, atc. (Specify | At home, farm, atreet, | actory, offica | 28f. LOCATION (Stree City or Town, Sta | et and Number or ite) | Rural Route Number, | | | | |
| COMPLETED | | | | e time, data and placa, and due y opinion, daath occured at the | | | cause(a) and manner as stated. | | | | |
| TO BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | Donne | eller | 29c. LICENSE NU | 070-3 | N 1- | SIGNED (Month, Day, Year) | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO C | OMPLETED CAUSE OF DEAT | H (ITEM 27) (Type, Print) | mo - | 75015 | York | Ri Tousm | | | | |
| | DEC 14 1990 guli | Devidson-Hand | | | | | | | | | |



1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

217-05-6244

RESIDENCE OF DECEDENT

4. SOCIAL SECURITY NUMBER

Herman

9e. FACILITY NAME (If not institution, give street end number)

4638 Marble Hall Road

5. SEX

1 M 2 F

Pages 1, 2, 3 should

IRECTOR

DIVISION OF VITAL RECORDS P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

| #. & | 10 | MD | | BAI | TIMORE, CI |
|--|-----------------------|--|---|--|--|
| it permit, | RAL | 100. STREET AND NUMBER 4638 MARBLE H | IALL ROAD | | 101. ZIP CODE |
| ing physician. the bunal-transit | BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 X Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 X NO | 2 1 2 3 9 13. WAS DECENDENT OF HISI If yes, specify Cuben, Mex 1 YES 2 NO Spe |
| as as | ED | 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DECEDENT'S USU | IAL OCCUPATION |
| 등은 | COMPLET | Elementary/Secondary (0-12) 9 t h | College (1-4 or 5+) | | done during most of working lived.) |
| by the hospital be detached for at once. | | 17. FATHER'S NAME (First, Middle, Lest) BRIGHTY RATHE | R | | 18. MOTHER'S NAN |
| retained 5 should notffled | TO BE | 19a. INFORMANT'S NAME (Type/Print) CARRIE JENNING | | | DRESS (Street and Number or Ru |
| e 6 may be ector, page : must be n | | 20e. METHOD OF DISPOSITION X X Burlel 2 Cremation 3 Remo | oval from State | | ON (Name of cemetery, crematory |
| ter death. Page 6 m the funeral director, val. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | 22. NAME AND ADDRESS OF |
| rs after de: 1 by the furemoval. | - 3 | 23. PART 1. Enter the diseases, or c | masch | | WM.C. MARC |
| on the physician and completely filled in by the physician and completely filled in by the physician burial, cremation, or removation or the physician and completely filled in by the physician and completely filled in by the physician and the physician of the physician and the phys | MEDICAL CERTIFICATION | shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition | DUE TO (OR AS DUE TO (OR AS | DSTRUCTIVE A CONSEQUENCE OF): A CONSEQUENCE OF): | e pulmonary di |
| CIAN: The law ertificate has the the State Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXES 2 \(\text{NO}\) 27. MANNER OF DEATH XX Netural 6 \(\text{Pending}\) | HOSPITAL: 1 Inpatiant 2 ER/Out 28e. DATE OF INJURY (Month, Day, Year) | | WORK? |
| TTENDING TOR: After after death | red BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJUR building, etc. (Spi | IY — Al home, farm, streedly) | |
| AL DIRE | COMPLETED | (Crieck Girly | | | it the time, dete end place, and in my opinion, death occured at |
| TO THE HOSPIT TO THE FUNER be filed within | O BE C | ESS. SIGNATURE AND TITLE OF CENTIFIES | 2/ | | 29c. LICENSE |
| | F | MAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF O | EATH (ITEM 27) (Type, Pri | int) |

32. REGISTRAR'S SIGNATURE Nevidson-Rande

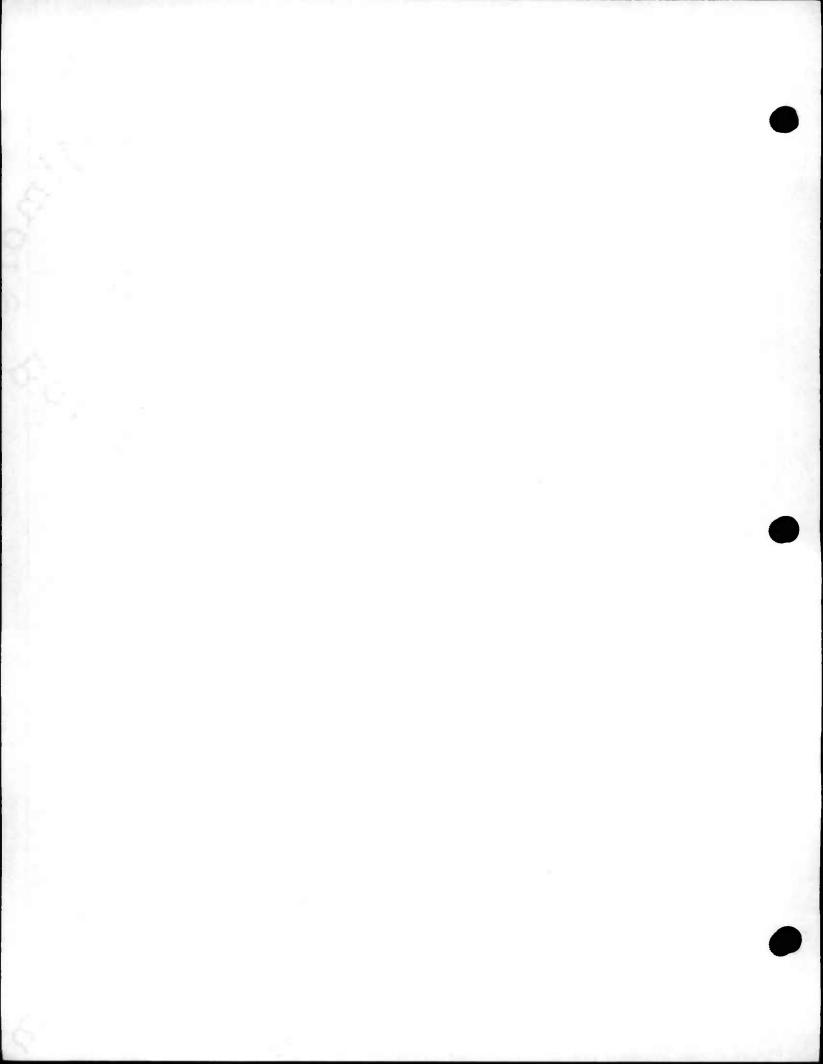
FRANK PERETTI, MD

31. DATE FILED (Month, Day, Year)

90 34242

| STATE OF N | MARYL | | DEPAR | | | | | | ME | ENT/ | | YGIEN | E | 0 | | 1 (45 |
|--|--------------------------------|---------------------|------------------------------------|--------|-----------------|------------|--|-----------------|----------------------|--------|-----------|------------------------|-----------|------------------|---------|--|
| | | | nnin | | | | | | 2 | MON | E OF D | | Y) | YEAR | | TIME OF DEATH |
| 5. SEX | 8. AGE (In yrs. lest birthday) | | | | | | | THPLA | CE (State or Foreign | | | | | | | |
| et end number) Road | | | | 9b. | спу, | | | MOLE | | | | | 9c. CO | UNTY OF | DEAT | н |
| | | | 10c. CIT | | | | | , CI | ТҮ | - | | | | | | 1. INSIDE CITY LIMITS? // YES 2 // NO |
| ALL RO | A D | | | | | | H. ZIP | 239 | | | | | - | TIZEN OF | WHA | COUNTRY? |
| FORCES? 1 | YES | 2 💢 N | MED O | | B | | pecify | Cuben, Mex | | | | | or No- | Bla | ick, W | American Indian, hita, atc. |
| TION impleted) College (1-4 or 5 | +) | (G/ l/la. | CEDENT'S We kind of Do NOT u | work d | done d red.) | during me | ost of | | | | | | | NDUSTRY | | LAY CO. |
| ₹ | | | | | | 0 2 | - | MOTHER'S NAN | | (First | t, Middle | , Maiden | Surname) | | | |
| S | | | | | | | | HALL | | | | | | | MC | 21239 |
| al from State | 201 | RUI | lense | | GE | CI | ΕM | ETER | Υ | | | | | _ City or / I | | MD. |
| mas | ch | | | | | | | MARC | | | Н. | 110 |)1 E | Ξ. Ν | 10 R | TH AVE. |
| mplications the | use on e | ach line | • | | | | | | | | | or resp | iratory a | arrest, | | Approximate interval Batween Onset and Death |
| Chron DUE TO | O (OR AS | | | | pu | ATIIK | ona | iry ai | se | as | e | | | | | |
| DUE TO | OR AS | A CONSEC | DUENCE C | P): | | | | | | | | | | | | |
| DUE TO | OR AS | A CONSE | QUENCE (| OF): | | | | | | | | | | | | |
| PERFORMED? 1 YES YEX NO ON | | | | | | | ERE AUTOPSY FINDINGS BALLABLE PRIOR TO MPLETION OF CAUSE F DEATH? YES XX NO | | | | | | | | | |
| HOSPITAL: | □ ED/0.4 | noblest 0 | □ DO 4 | | HEF | R: | | OF DEATH | | | | | | | | |
| 28e. DATE O | | patient 3 | 28b. Til | _ | _ | 28c. IN | _ | AT NO | _ | _ | | | INJURY C | OCCURED | | |
| 26e. PLACE building | OF INJUR | Y — Al ho icify) | me, ferm, | stree | t, faci | lory, offi | ice | | - | 261. L | OCATIO | N (Street wn, State | end Numi | ber or Run | ni Rout | te Number, |
| AN: To the best of | | | | | | | | | | | | | | | no(a) a | nd manner ee stated. |
| 1 | | | - | | | | | c. LICENSE | | ER | | | | ATE SIGN | ED (M | onth, Day, Year) |
| COMPLETED CA | USE OF O | EATH (ITE | М 27) (Тур | | | Per | nn | Stree | et. | Ba | lti | more | , MD | 212 | 01 | V |

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| VISION | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If them 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG., NO. REG. NO.

| | 1. DECEOENT'S NAME (First, Middle, Last) KURAS | | 2. DATE OF DEATH MONTH DAY | year 3. TIME OF DEATH | | | | | | | | |
|---------------|--|---|--|--|--|--|--|--|--|--|--|--|
| | A THE STATE OF THE | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTHPLACE (State or Foreign Country) | | | | | | | | |
| | ムワーじーン/イン | b. CITY, TOWN OR LOCATION OF DE | ATH 9c. COUNT | TY OF DEATH | | | | | | | | |
| D HO | Stella Maris | TOWSON | Ba | timore | | | | | | | | |
| DIRECTOR | | OWN OR LOCATION | | 10d. INSIDE CITY LIMITS? | | | | | | | | |
| | 10e. STREET AND NUMBER | 10f. ZIP CODE | 10g. CITIZ | 1 N YES 2 NO EN OF WHAT COUNTRY? | | | | | | | | |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | ST. 3/0 | 330 U | 14. RACE American Indian, | | | | | | | | |
| | 1 Naver Merried 2 Merried FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | If yee, specify Cuben, Mexice 1 YES 2 NO Specify | n, Puerto Ricen, etc.) | Bleck, White, atc. Specify: | | | | | | | | |
| LED BY | 15. DECEDENT'S EDUCATION 16a. DECEDENT'S US | UAL OCCUPATION k done during most of working | 18b. KIND OF BUSINESS/INDU | JSTRY JSTRY | | | | | | | | |
| . II | Elementary/Secondary (0-12) College (1-4 or 5+) | EMAKER | | | | | | | | | | |
| COMPL | 17. FATHER'S NAME (Eds., Middle, Last) | 18. MOTHER'S NA | ME (First, Middle, Maiden Surname) | ECRT | | | | | | | | |
| O BE | 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING AC | DDRESS (Street and Number or Rural | Route Number, City or Town, State, Zip | Code) 21087, MD. | | | | | | | | |
| ۲ | FRANK KUPRES 2K 200, METHOO OF OISPOSITION 200. PLACE OF DISPOSITION | ON (Name of cemetery, crematory or | 1 FF COUR | KINCSVILLE | | | | | | | | |
| | Burlei 2 Cremetion 3 Removal from State 1 Donetion 5 Other (Specify) | ROSSCEM | ETERY GOVK | TCHIE HIGHWAY | | | | | | | | |
| 1 | 21. SIGNATURE OF FUNERAL BERVICE LICENSEE | 22 NAME AND ADDRESS OF FA | flenens | Dierdag | | | | | | | | |
| - | 23. PART I. Enter the diseases, or complications that caused the death. Do not | enter the mode of dying, suc | th as cardiac or respiratory arre | Approximete | | | | | | | | |
| i | shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final | Mala | | Interval Between Oneet and Deeth | | | | | | | | |
| | disease or condition resulting in death) a. Metastatic Melanoma Due to (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| NO | Sequentially list conditione, b. Due to (or as a consequence of): | | | | | | | | | | | |
| CERTIFICATION | If any, leading to immediate ceuse. Enter UNDERLYING | | | | | | | | | | | |
| RTF | thet initieted evente DUE TO (OR AS A CONSEQUENCE OF): reculting in death) LAST | | | | | | | | | | | |
| | PART II. Other eignificant conditions contributing to death but not resulting in | the underlying cause given in | Part I. 24e. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | | | | | | | |
| MEDICAL | | | 1 YES 2 NO | COMPLETION DF CAUSE OF DEATH? | | | | | | | | |
| [| | | | 1 TYES 2 NO | | | | | | | | |
| PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 | 28. PLACE OF OEATH (CHOTHER: Nuraing Home 5 - Reeldence | | | | | | | | | | |
| PHYS | 27. MANNER OF OEATH 28e. OATE OF INJURY 28b. TIME ((Month. Day, Year) INJUR | OF 28c, INJURY AT | 28d. OEȘCRIBE HOW INJURY OCC | CURED | | | | | | | | |
| ⋒ | 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 5 Could get be 28e PLACE OF INJURY — At home, farm, stn | M 1 YES 2 NO | 281. LOCATION (Street and Number | or Rural Route Number, | | | | | | | | |
| | 4 Homicide determined building, etc. (Specify) | | City or Town, Stata) | | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred one) 2 MEDICAL EXAMINER: On the basic of axamination and/or investigation, | | | | | | | | | | | |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NU | MBER 29d. DATE | SIGNED (Month, Day, Year) | | | | | | | | |
| ٩ | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, P | rint) | 11 11 | 2-15-10 | | | | | | | | |
| | Carla A. Alexander N 31. OATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | M.D. St | ella Mari | S | | | | | | | | |
| | DFC 14 1990 Julia Sevidon Rendelle | | | | | | | | | | | |
| | () | | | DHMH-16 Rev 1/89 | | | | | | | | |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| FOR STATE REGISTRAR | STATE OF MARYLA | | | OF DEATH | | REG. NO. | | 0 34244 |
|--|---|---|--|--|---|---|--------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | OLITTI | IOAIL | OI BEATT | 2. 0 | DATE OF DEATH | | 3. TIME OF DEATH |
| | E. JOHN | T D % | VID | | | 2/7/199 | | 11:05P M |
| KNEEBON 4. SOCIAL SECURITY NUMBER | | n yrs. last birthday) | IF UNDER 1 Y | EAR IF UNDER 24 | HR\$. 7. 0 | ATE OF BIRTH | 8.1 | BIRTHPLACE (State or Foreign |
| 354 16 5400 | 1 km 2 F 63 | | MONTHS C | AYS HOURS | mers. | Month, Day, Year) - 27-27 | (| Country) Illinois |
| 9e. FACILITY NAME (If not institution, give stre | | | 9b. CITY. T | OWN OR LOCATION | | -21-21 | 9c. COUNTY | |
| 1505 Bedworth | • | | | ıthervi | | | Ba 1 | Ltimore |
| RESIDENCE OF DECEDENT | Road | | | A CHICL VI | 12.0 | | 24. | |
| 10a. STATE 10b. COUNTY | | 10c. CIT | Y, TOWN OR | | _ | | | 10d. INSIDE CITY |
| MD | Balto Co | | Lu | thervil | le | | | 1 YES 2 NO |
| 10s. STREET AND NUMBER | | | | 101. ZIP CODE | | 1 | 10g. CITIZEN | OF WHAT COUNTRY? |
| 1505 Bedwort | h Road | | | 2109 | 3 | | US | SA |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN | U.S. ARMED | 13, WA | S DECENDENT OF | HISPANIC O | RIGIN? (Specify Yee | or No.— 14. | RACE — American Indian, |
| 1 Never Merried 2 1 Merried | FORCES? 1 YES | 2 NO | ff y | es, specify Cuben, YES 2 NO | Mexican, Pu | erto Rican, etc.) | | Black, White, etc. Specify: |
| 3 Widowed 4 Divorced | A | ΙΙ | '' | J TES 2 NO | эресну. | | | White |
| 15. DECEDENT'S EDUCA | ATION | 16a DECEDENT'S | USUAL OCC | UPATION | | 16b. KIND OF BUSI | NESS/INDUS | TRY |
| (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done dui se retired.) | ing most of working | | | | |
| 12+ 3 | y e s | Self | Empl | oyed(Pr | esid | ent) Po | wer ! | Tools Repair |
| 17. FATHER'S NAME (First, Middle, Last) | yes | | | | | First, Middle, Maiden S | | |
| JOHN R. KNEE | PONE, | | | ELLE | N M | ALTES | | 1 1 |
| | DONE | 405 104 11 101 | ADDRESS / | | | Number, City or Town | Stete 7in Co | ofa) |
| 19e. INFORMANT'S NAME (Type/Print) | | | | | | | | |
| Emily O. Knee | | | | | | | | e,MD 21093 |
| 20a. METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Remo | | other place) | SITION (Name | of cemetery, crema | tory or | 20c. LOC | ATION — City | y or Town, State |
| 4_Donation 5 Other (Specify) | 361 C-13-72- | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE Ronald | Wade, Di | r 22. N/ | ME AND ADDRESS | OF EVCITL | 'Anatgom | y Bo | ard |
| V Santa La | | 2/13/90 | | | | _ | _ | alto, MD21201 |
| 1 conungi | 7 7 90 | | | | | | | |
| 23. PART I. Enter the diseases, or co | | | | | _ | | | Interval Between |
| IMMEDIATE CAUSE (Finel | 1 - 1 | . 10. | 1 | | | Leur | 10000 | Onset and Death |
| disease or condition resulting in death) | Hrut | E/M | Mill | escuo | us | - Lew | win | ca 3 mos |
| resulting in death) | DUE TO (OR AS A | CONSEQUENCE | A): | | | | | |
| | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE | OF): | | | | | |
| cause. Enter UNDERLYING | | | | | | | | |
| CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | CONSEQUENCE | DF): | | | | | |
| resulting in death) LAST | | | | | | | | |
| | · — — — — — — — — — — — — — — — — — — — | | | | | | | |
| PART II. Other aignificant conditions | contributing to death b | out not reculting | In the und | erlying ceuse gi | ven in Par | t J. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | | | | | |
| | | | | | | 1 1 T YES 2 | | COMPLETION OF CAUSE |
| | | | | | | 1 TYES 2 | [] NO | OF DEATH? |
| | | | | | | 1 🗆 YES 2 | [] NO | |
| ar was over opposed to weeken | | | | 28 B4 ACE OF DE | ATM (Chaok | - | [] NO | OF DEATH? |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER | 26. PLACE OF DE | ATH (Check | - | | OF DEATH? |
| EXAMINER? 1 YES 2 NO | 1 Inpatient 2 ER/Out | | 4 🗆 Nursi | ng Home 5 🗆 Res | idence 6 | only one) Other (Specify) | | OF DEATH? 1 YES 2 NO |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | | 28b. TI | 4 🗆 Nursi | | idence 6 | only one) | | OF DEATH? 1 YES 2 NO |
| EXAMINER? 1 | 1 Inpatient 2 ER/Out | 28b. TI | 4 🗆 Nursi | ng Home 5 - Res | idence 6 C | only one) Other (Specify) | | OF DEATH? 1 YES 2 NO |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 ER/Out | 28b. Ti | 4 🗆 Nurel | ng Home 5 Red RSc. INJURY AT WORK? 1 YES 2 | NO 28 | only one) Other (Specify) d. DESCRIBE HOW III | NJURY OCCU | OF DEATH? 1 YES 2 NO |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | 1 Inpatient 2 ER/Out | 28b. Ti | 4 🗆 Nurel | ng Home 5 Red RSc. INJURY AT WORK? 1 YES 2 | NO 28 | Other (Specify) | NJURY OCCU | OF DEATH? 1 YES 2 NO |
| EXAMINER? 1 YES 2 NO 27. MANNER DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER | 1 Inpetient 2 ER/Out | 28b. Ti | 4 Nursi | ng Home 5 Ree REC. INJURY AT WORK? 1 YES 2 | NO 26 | only one) Other (Specify) d. DESCRIBE HOW II LOCATION (Street City or Town, State) | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSIC | 1 Inpatient 2 ER/Outs 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | 7 — At home, farm | ME OF SURRY M Street, facto | ng Home 5 Res | NO 28 | only one) Other (Specify) d. DESCRIBE HOW II LOCATION (Street City or Town, State) | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 1 Inpatient 2 ER/Outs 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, atc. (Spe | 7 — At home, farm | ME OF SURRY M Street, facto | ng Home 5 Res | NO 28 | only one) Other (Specify) d. DESCRIBE HOW II LOCATION (Street City or Town, State) | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, I. cause(s) end manner ee stated. |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only) 1 CERTIFYING PHYSIC | 1 Inpatient 2 ER/Outs 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, atc. (Spe | 7 — At home, farm | ME OF SURRY M Street, facto | ng Home 5 Res REC. INJURY AT WORK? 1 YES 2 Ty, office The, date and place, sinion, death occurrence. | NO 28 | only one) Other (Specify) d. DESCRIBE HOW II H. LOCATION (Street City or Town, State) the cause(a) and mare, date end place, an | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, |
| EXAMINER? 1 YES 2 NO 27. MANNER DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 1 Inpatient 2 ER/Outs 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, atc. (Spe | 7 — At home, farm | ME OF SURRY M Street, facto | ng Home 5 Res REC. INJURY AT WORK? 1 YES 2 Ty, office The, date and place, sinion, death occurrence. | NO 28 end due to it dut the time | only one) Other (Specify) d. DESCRIBE HOW II H. LOCATION (Street City or Town, State) the cause(a) and mare, date end place, an | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, I. cause(s) end manner ee stated. |
| EXAMINER? 1 YES 2 NO 27. MANNER DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 28e. DATE OF INJURY (Month, Dey. Year) 28e. PLACE OF INJURY 28e. PLACE OF INJURY building, atc. (Spe CIAN: To the best of my know R: On the basis of examination | 28b. Ti | 4 Nursi | ng Home 5 Res REC. INJURY AT WORK? 1 YES 2 Ty, office The, date and place, sinion, death occurrence. | NO 28 end due to it dut the time | only one) Other (Specify) d. DESCRIBE HOW II H. LOCATION (Street City or Town, State) the cause(a) and mare, date end place, an | NJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, I. cause(s) end manner ee stated. |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINE 30. NAME AND ADDRESS OF PERSON WHO | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe CIAN: To the best of my know R: On the basis of examination COMPLETED CAUSE OF DI | 28b. Till 7 — At home, farm city) viedge, death occu on end/or investigat WWD EATH (ITEM 27) (Ty) | ME OF HURST MM , street, facto | ng Home 5 Res Rec. INJURY AT WORK? 1 YES 2 Try, office re, date and place, inlon, death occurs 29c. LICE | NO 28 | only one) Other (Specify) Id. DESCRIBE HOW if City or Town, State) The cause(s) and mar e, date end place, an | nJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(e) end manner ee stated. SIGNED (Month, Day, Year) |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER 1 CERTIFYING PHYSIC (Check only one) 2 MEDICAL EXAMINE 29b. SIGNATURE AND TIME OF CARTIFIES 30. NAME AND ADDRESS OF PERSON WHO | 28e. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Control of the basis of examination of examination of the basis of examination of | 28b. Till 7 — At home, farm city) viedge, death occu on end/or investigat WWO EATH (ITEM 27) (Ty) Pierre | ME OF HURSE HALL STREET HE HALL STREET HALL STREET HALL STREET HALL STREET HALL STREET HAL | ng Home 5 Res Rec. INJURY AT WORK? 1 YES 2 Try, office re, date and place, inlon, death occurs 29c. LICE | NO 28 | only one) Other (Specify) Id. DESCRIBE HOW if City or Town, State) The cause(s) and mar e, date end place, an | nJURY OCCU | OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(s) end manner se stated. SIGNED (Month, Day, Year) |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

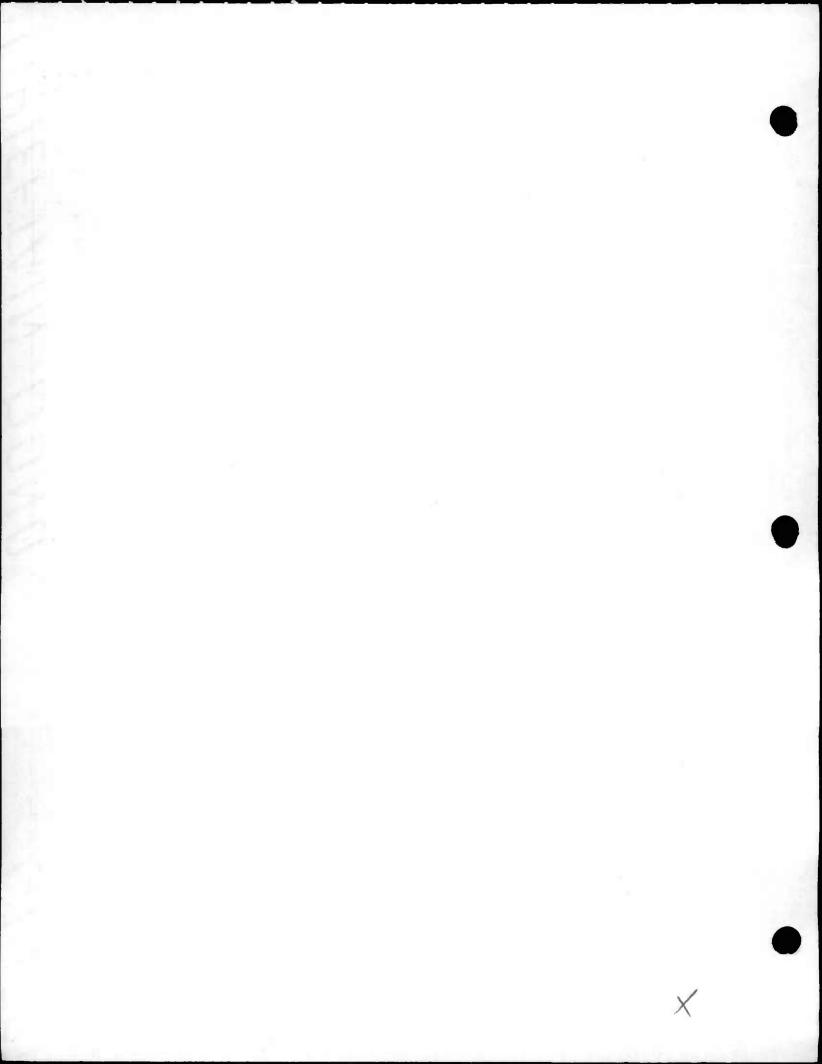
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital of attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached lin uncertain the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

mours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a mount of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 1 | FOR STATE REGISTRAR |
|---|---------------------------|
| | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | CERTIFIC | ATE OF | DEATH | RE | G. NO. | | | | |
|------------------|--|--|---|--|---------------------------------------|---------------------------|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Maria Luciano | | | | 2. OATE OF D MONTH De cemb | | 1990 | 3. TIME OF DEATH | | |
| | 218 32 4024 1 D M 2 X F | 90 YRS. | UNDER 1 YEAR HTHS DAYS | IF UNDER 24 HRS, HOURS MIN, | 7. DATE OF BI (Month, Day 07/16 | /0°0 | Count | Italy | | |
| TOR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH 9c. COUNTY OF DEATH Baltimore Counters of December 1 | | | | | | | | | |
| FUNERAL DIRECTOR | Maryland Baltimore County | | OWN OR LOCA | ION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| VERAL | 1920 Holly Neck Road | | 101. ZIP CODE 21.2 | | | 10g. Ci | U.S. | | | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 2 Married 1: Yes, GIVE WAR OR | S 2 NO | If yes, sp | ENDENT OF HISPAN scify Cuban, Maxicai 2 NO Specify | n, Puarto Rican | | No— 14. RACE — American Indian, Black, White, atc. Specify: | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4 or 5 +) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | UAL OCCUPATION of done during montred.) | DN st of working | 16b. KINI | OF BUSINESS/II | | | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NAI | ME (First, Middle | | | | | |
| BE C | Augustine Cilenzi | | | Maria | Miche] | line Car | amni | la | | |
| D B | 19a. INFORMANT'S NAME (Type/Print) | | | nd Number or Rural F | | | | | | |
| - | Augustine Luciano | 06. PLACE OF DISPOSITI | | ck Road I | Balt1m | 20c. LOCATION - | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | Holy Redee | | ,,, | | Baltimo | - | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME A | D ADDRESS OF FAC Zinski Fi | uneral | | | <u>, , , , , , , , , , , , , , , , , , , </u> | | |
| - | your sulles and | | 1407 | Old Easte | ern Ave | Balto. | . Md | 21221 | | |
| | 23. PART / Enter the diseases, or complications that ceue ahock, or heart failure / List only one ceuse on IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (or AS | eech ilne. | | faclu | | or respiratory e | erreat, | Approximate Interval Between Onset and Death | | |
| CATION | Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST C. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | PART II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part i. | | | | | | Y 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| MEDICAL | CVA Drantes | | | | | | | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| ä | | | | | | | | | | |
| ic/ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 NO HOSPITAL: 1 Inpetient 2 PR/Ox | | THER: | ACE OF DEATH (Ch | | | _ | | | |
| BY PHYSICIAN: M | 27. MANNER OF DEATH 1 Natural 5 Pending 28a. DATE OF INJURY (Month, Day, Year, | Y 28b. TIME (| OF 28c. IN | NO 5 Medidence NURY AT NRK? YES 2 NO | | ecity) BE HOW INJURY O | CCURED | | | |
| | 2 Accident Investigation 3 Suicide 8 Could not be distarmined 4 Homicide Suicide 1 Could not be distarmined Investigation 28a. PLACE OF INJURY — At home, farm, street, factory, office building, stc. (Specify) 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beet of my known one) | | | | | | | (a) and menner as stated. | | |
| TO BE (| 29b. SIGNATURE AND TITLE OF CERTIFIER N | 11) | | D 38 | 390 | • | 12. | D (Month, Day, Year) -//-90 | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF I | | 50 Ec | sten 1 | he F | alhn | ne | mb 21224 | | |
| | 31. DATE FILED (Month, Day, Year) DEC 14 1990 Fishe Sair | don-Fondale | W | | | | | | | |



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DIVISION OF VITAL RECORDS, P.O. BOX 13146,

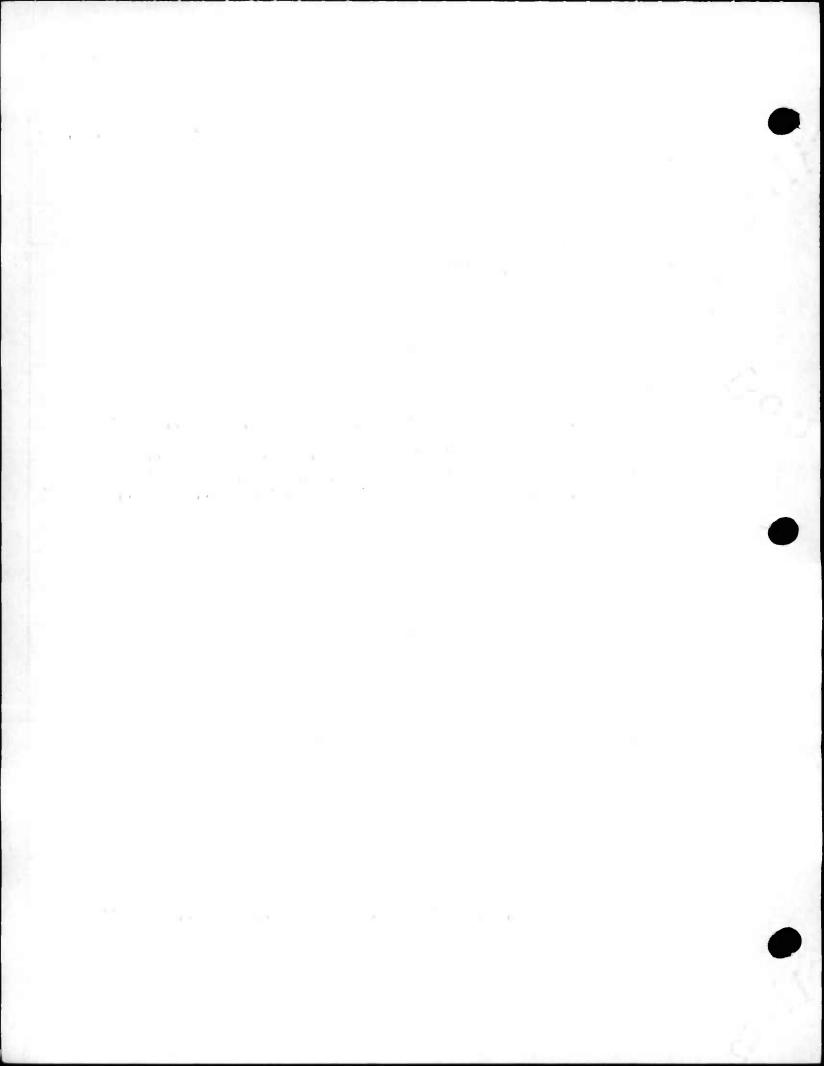
| ysiciali. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 | | |
|-----------------|--|---------------|------------|
| מונהווחווח ה | se as the b | | |
| in indent | ached for u | | Ce. |
| ion of nic | onld be det | | led at on |
| ay be recan | page 5 sho | | be notifi |
| age o me | al director, | | ner must |
| itel Death. | the funer | loval. | al exami |
| 5 CINOII 47 | filled in by | ion, or rem | the medic |
| TIED WILLIAM | completely | rial, cremat | c event. |
| מם חב בצברו | ysician and | prior to bu | traumat! |
| מנוו רבו וווורי | ttending ph | al Hygiene | or other |
| Illat trie ue | ed by the a | h and Mem | any Inlury |
| w requires | been signe | pt. of Healt | 3 shows 2 |
| IAN: Ine la | tificate has | e State De | nr Item 2 |
| NG PHYSIC | fter this ce | eath with the | marked |
| R ALIENDE | RECTOR: A | urs after de | m 28 ls |
| OSPITAL U | UNERAL DI | ithin 72 ho | ANT IF HA |
| D THE H | TO THE F. | be filed w | MPORT |
| | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | 1 - FOR STATE OF MARYLAN | D / DEPARTM CERTIFICA | | | ENTAL HYGIEN | E | | | | |
|--|--|---|-------------------|--|--------------------------------------|------------------|---|--|--|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH MONTH DA | y YEAR | 3. TIME OF DEATH | | | |
| i | Francis Frederick Leary | Francis Frederick Leary | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (in yr. | | 12 11 | 90 å. BIR | THPLACE (State or Foreign | | | | | |
| | | 218-07-4135 1 M 2 F 73 VRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) Mary | | | | | | | | |
| | Se. FACILITY NAME (If not institution, give street and number) | 9b. | CITY, TOWN O | R LOCATION OF DEA | тн | 9c. COUNTY OF | DEATH | | | |
| BY FUNERAL DIRECTOR | 2820 Maudlin Avenue 212 | 230 | Balt: | imore | | | | | | |
| ច្ឆ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10c, CITY, TO | WN OR LOCAT | ON | | | tod, INSIDE CITY | | | |
| 5 | Maryland | | Balt | moro | | | LIMITS? | | | |
| ار | 10e. STREET AND NUMBER | | | ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| 8 | 2820 Maudlin Avenue, | | | 21230 | _ 1 | 1 | JSA | | | |
| 3 | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S | S. ARMED | | ENDENT OF HISPANI | C ORIGIN? (Specify Yea | | CE — American Indian, ack, White, atc. | | | |
| 7 | 1 Never Married 2 Married FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | If yes, spe | city Cuban, Mexican, 2. NO Specify: | , Puarto Rican, atc.) | | ock, white, atc. | | | |
| | 3 Widowed 4 Divorced | | | 3 . | | | White | | | |
| | 15. DECEDENT'S EDUCATION 16. (Specify only highest grade completed) | (Give kind of work | done during mos | | 16b. KIND OF BUS | INESS/INDUSTRY | | | | |
| COMPLETED | Elementary/Secondary (0-12) College (1-4 or 5+) 1 2 th | Tool & | | | | | 1 | | | |
| ₹ I | | T001 & | рте | | | | | | | |
| ႘ ၂ | 17. FATHER'S NAME (First, Middle, Last) James Leary | | | | NE (First, Middle, Maiden | Surname) | | | | |
| 띪 | 19a. INFORMANT'S NAME (Type/Print) | I 405 MAII 1110 AD | anne m | Kate (| oute Number, City or Tow | - 00 to 70 0 do | | | | |
| 임 | Constance M. Leary | 1 | | | - | | 01.000 | | | |
| | | ACE OF DISPOSITIO | MAUGI | in Avent | ie. Balt | CATION — City or | ZIZ3U | | | |
| 1 | 1 □ Burial 2 X Cramation 3 □ Ramoval from State | etro Cre | · | | | | | | | |
| | 21. SIGNATURE OPFUNERAL SERVICE TOENSEE | 010 010 | 22 NAME AN | D ADDRESS OF EAC | H PTV | | | | | |
| | Sery E. The Te | | Crer | nation S | Society | of Mar | yland | | | |
| | George E. MacNabb | | | | | | , MD 21228 | | | |
| | 23. PART I. Enter the disesses, or complications that caused the shock, or heart failure. List only one cause on aech | | enter the mo | de of dylng, such | as cardlec or respi | ratory errest, | Approximate Interval Between | | | |
| | IMMEDIATE CAUSE (Final | . 1 | | | | | Onset and Death | | | |
| - 1 | disease or condition a. Congest | ove Klat Failus | | | | | | | | |
| - 1 | DUE TO (OR AS A CC | ONSEQUENCE OF): | 1-4. | | | | i I | | | |
| CERTIFICATION | Sequentially list conditions, Dialete. Due to (or As A co | ONSEQUENCE OF): | (, 10 | | | | <u> </u> | | | |
| ¥ | If any, leading to immediate cause. Enter UNDERLYING | Denc | e d | zi here | | | | | | |
| ᇤ | CAUSE (Disease or Injury that initiated events | ONSEQUENCE OF): | | | | | | | | |
| 토 | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST | al At t | en] | Diccas | | | | | | |
| | PART II. Other significent conditions contributing to deeth but | | | | | AUTODOV | 4b. WERE AUTOPSY FINDINGS | | | |
| SAL. | Blindres | not resulting in t | ne underlyin | s cause given in i | PERFO | RMED? | AMILABLE PRIOR TO COMPLETION OF CAUSE | | | |
| | 13/126707 | | | | 1 YES 2 | . ހNO | OF DEATH? | | | |
| Ξ | | | | | _ | | 1 TYES 2 NO | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | ACE OF DEATH (Che | | | | | | |
| 2 | EXAMINER? HOSPITAL: | | THER: | | | | | | | |
| PHYSICIAN: MEDI | 1 ☐ YES 2 🔀 NO | 26b, TIME O | - | e 5X Residence | 6 Other (Specify) 28d. DESCRIBE HOW | N II IDV OCCUBED | | | | |
| | 1 ☑ Natural 5 ☐ Pending (Month, Day, Year) | WC | PRK7 | 200. DESCRIBE NOW | NOON OCCONED | | | | | |
| В | 2 Accident Investigation 3 Suicide 6 Could not be 28e. PLACE OF INJURY — | and Number or Rur | ral Route Number, | | | | | | | |
| | 4 Homicide determined building, etc. (Specify) | City or Town, State | | e section . | | | | | | |
| Solution of the determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner as stated. | | | | | | | | | | |
| | | | | | | | | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | D30/ | | ≥ /2// | NED (Month, Day, Year) | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH | H (ITEM 27) (Time Date | nt) | 0001 | 06 | 10/1 | 4/ 70 | | | |
| | | | | Λ | D-14 | nan c | 1,000 | | | |
| | William M. Russell, M. D. | HARLE DE | o. cat | on Ave. | , Barto | IVID 2 | 1229 | | | |
| | 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | | | | | | |





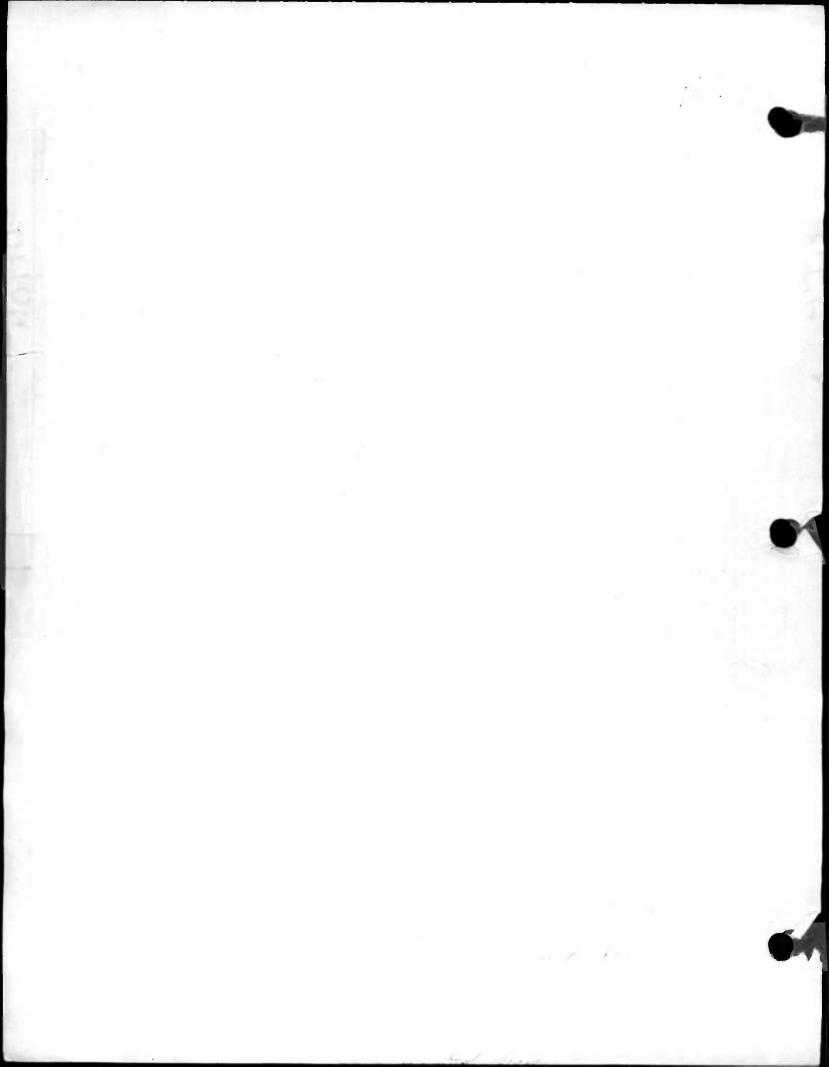
| death certificate be executed within convince after death. Page 6 may be retained by the hospital or attending physician. | mineraling physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use and completely provided by the provided burial completely provided by the provided burial completely provided by the provided burial completely provided by the provided burial completely provided by the provided burial completely provided by the provided burial completely provided burial completely provided by the provided burial completely provided | or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| TO THE HOSPITAL OR ATTENDING PRYSICIAN. The IN 1865 TO | TO THE FUNERAL DIRECTOR After this certificate test copies the find within 72 hours after death with the State Deci. | IMPORTANT If Ham 28 is marked or than 23 thousand |

DEC 1 4 1990

32. REGISTRAR'S SIGNATURE

| - 6 | * REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | | CI | ERITI | CATE OF | DEATH | 2. DATE OF DE | G. NO. | | 3. TIME OF DEATH |
|---|--|--|---|---|---|--|--|--|--|--|
| 1 | Jerome | | Α. | | Lee | | MONTH | 0-90 | YEAR | |
| 1 | | 5. SEX | 6. AGE (In yrs. las | at historiani) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BII | | e BIRTI | 4:54PM HPLACE (State or Foreign |
| | The second second second | 1 DAN 2 - F | 30 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, | Year) | Count | try) |
| | 2/2 56 8450 9e. FACILITY NAME (If not institution, give stre | 7 17 | 121 | | ah CITY TOWN | OR LOCATION OF DE | 8-32 | 9c, COU | | RYLAND |
| . | Harbor Hospital Baltimore City | | | | | | | | | |
| | RESIDENCE OF DECEDENT | | | | Dal | crinore c | ıty | | | |
| | 10e. STATE 10b. COUNTY | | | 10c. CITY | TOWN OR LOCA | TION | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAUN | | | 13/ | TATI M | ORE | | | | 1 TES 2 NO |
| | 10e. STREET AND NUMBER | | _ | | 10 | H. ZIP CODE | | | | WHAT COUNTRY? |
| | 1028 BETHU | NE 7 | POAD | | | 21225 | | 10 | 1.5. | A |
| | 11. MARITAL STATUS | 12. WAS DECEDE | NT EVER IN U.S. AF | | | CENDENT OF HISPAI | | | 14. RAC | E - American Indian, ck, White, atc. |
| | 1 Never Merried 2 Merried | | 1 🗌 YES 2 🖫 WAR OR DATES | NO | | pecify Cuben, Mexica S 2 140 Specif | | atc.) | Spec | |
| . 11 | 3 Widowed 4 Divorced | | | | | | | | B | LACK |
| | 15. DECEDENT'S EDUCA (Specify only highest grade or | | (6 | ive kind of w | OSUAL OCCUPAT ork done during m | | 16b. KIND | OF BUSINESS/INC | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | Do NOT use | | | | | | |
| | | | | INC | mPLU | | | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | _ | | | 2 | 16. MOTHER'S NA | ME (First, Middle, | Melden Surname) | - | |
| | FRANK LEE | | | | | LLIZA | BETH | - | _ | 7414 |
| | 19e. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (Street | and Number or Rural | Route Number, Cl | y or Town, State, Zip | Code) | • |
| - | | AVAC-E | | <u> </u> | OIHE | | <u>na Ka</u> | | 1 2 | 11239 |
| | 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or After place) 20c. LOCATION — City or Town, State | | | | | | | | | |
| | | | | | | | | | | |
| ĺ | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 22. NAME AND ADDRESS OF FACILITY 23. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | | | | | | | |
| - 1 | Lorge L. L. Russ 2222 W. NORTH AVE BAKTUMO 21216 | | | | | | | | | |
| | 1 1 h 6 | > | | | 220 | 2 11 A | USS A | co Bara | . М- | 717/1 |
| + | 23 PART I Enter the diseases or or | CLL'S | et caused the d | eeth Do n | 728 | 2 Will | DRIH A | | | |
| | 23. PART I. Enter the diseases, or co shock, or haert fellure. L | | | | 728 | 2 Will | DRIH A | | | Approximete interval Batv |
| | shock, or haert fellure. L IMMEDIATE CAUSE (Final | ist only one ce | ouse on each lin | a. | ot enter the m | 2 Will | DRIH A | | | Approximete |
| | shock, or haert fellure. L | Narcot | cic into | xicat | ot enter the m | 2 Will | DRIH A | | | Approximete interval Batv |
| | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition | Narcot | ouse on each lin | xicat | ot enter the m | 2 Will | DRIH A | | | Approximete interval Batv |
| | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) | Narcot | cic into: | a. Xicat | ot enter the m | 2 Will | DRIH A | | | Approximete interval Batv |
| | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata | Narcot | cic into | a. Xicat | ot enter the m | 2 Will | DRIH A | | | Approximete interval Baty |
| | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | Narcot | o (or as a conse | EOUENCE OF | ion | 2 Will | DRIH A | | | Approximete interval Baty |
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| . 1 | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | Narcot DUE TO OUE TO | O (OR AS A CONSE | EQUENCE OF | ion | 2. W. Ma | Ch as cerdlec | or respiratory and | rest, | Approximete Interval Bate Onset and D |
| . 1 | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Narcot DUE TO OUE TO | O (OR AS A CONSE | EQUENCE OF | ion | 2. W. Ma | DIRTH A | WAS AN AUTOPSY PERFORMED? | rest, | Approximete Interval Bate Onset and D Onset and D ANALABLE PRIOR TO COMPLETION OF CAL |
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| THE CHARLES WITHOUT THE | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 1 Netural 5 Pending investigation | Narcot DUE TO DUE TO OUE TO CONTRIBUTING 1 I Inpatient 2 28a. DATE C (Month, FOUNI) 28e. PLACE | O (OR AS A CONSE O (OR | EQUENCE OF COURNES OF | ot enter the m ion ion iii iii iii iii iii ii | DODE OF DEATH (C) PLACE OF DEATH (C) THE S Residence NUMY AT ORK? YES 2 NO | Part I. 24e. 1 Part I. 24e. 1 Scheck only one) 8 Other (Sp. 28d. DESCRIE Unknow) 28f. LOCATIO | WAS AN AUTOPSY PERFORMED? KYES 2 NO NOTO E HOW INJURY OF | 24 | Approximate interval Batt Onset and D No. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? YES 2 \(\subseteq \) NO |
| TO DE LUI GIOUNE INTERIORE | shock, or haert fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificent conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 1 Netural 5 Pending | Narcot DUE TO DUE TO OUE TO CONTRIBUTING 1 I Inpatient 2 28a. DATE C (Month, FOUNI) 28e. PLACE | O (OR AS A CONSE O (OR | EQUENCE OF COURNES OF | ot enter the m ion ion iii in the underlyii | DODE OF DEATH (C) PLACE OF DEATH (C) THE S Residence NUMY AT ORK? YES 2 NO | i Part I. 24e. I Part I. 24e. S □ Other (Sp. 28d. DESCRIE Unknown) 28f. LOCATIO City or for | WAS AN AUTOPSY PERFORMED? E HOW INJURY OF MAIN CONTRACTOR OF MAIN CON | 24 CCURED | Approximete interval Batt Onset and D Onset and D AMILE PRIOR TO COMPLETION OF CALL OF DEATH? YES 2 NO |
| ED DE LUI GIOLOIS. MEDIONE | shock, or haert feliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide Could not be determined | Narcot DUE TO DUE TO OUE TO CONTRIBUTING t HOSPITAL: 1 Inpattent 2 28e. PLACE Building | O (OR AS A CONSE O (OR | e. XICAT EQUENCE OF EQUENCE OF resulting 3 DOA 28b. TIM 90 HOI | ot enter the m ion ion iii iii iii iii iii ii | ode of dying, such ode of dying, | Part I. 24e. 1 Part I. 24e. 12 1 Part I. 24e. 12 12 12 13 15 16 17 17 17 18 18 19 19 19 19 19 19 19 19 | WAS AN AUTOPSY PERFORMED? KYES 2 INO NO I (Street and Number Park) Bethune | 24 CCURED OF OF RUTAIN | Approximate interval Batt Onset and D No. WERE AUTOPSY FIND AMILABLE PRIOR TO COMPLETION OF CAL OF DEATH? YES 2 \(\subseteq \) NO |
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| COMPLETED BY THISICIAN: MEDICAL CENTRICAL | shock, or haert feliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? EXAMINER? 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide Could not be determined 29e. CERTIFIER CERTIFVING PAYSIC | DUE TO DUE TO DUE TO DUE TO OUE TO CONTRIBUTING t CONTRI | O (OR AS A CONSE O (OR | e. XICAT EQUENCE OF EQUENCE OF resulting 3 | ot enter the m ion : : : : : : : : : : : : : : : : : : | ode of dying, such ode of dying, | Part I. 24e. 1 Part I. 24e. 12 Description of the Country of the | WAS AN AUTOPSY PERFORMED? KYES 2 INO NO NO NO NO NO NO NO NO NO | 24 CCURED ROAC sted. | Approximate interval Baty Onset and D Onse |
| TO DE LUI GIOUNE INTERIORE | shock, or haert feliure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? ACMINER OF DEATH SOURCE ON TO MEDICAL EXAMINER OF DEATH SOURCE ON TO MEDICAL EXAMINER OF DEATH SOURCE ON TO MEDICAL EXAMINER OF DEATH SOURCE ON TO MEDICAL EXAMINER OF DEATH COULD NOT THE MEDICAL COULD NOT THE MEDI | Narcot DUE TO DUE TO OUE TO CONTributing t CONTributing t CONTRIBUTION POUNT 28e. DATE C (Month), FOUNT 28e. PLACE building CAN: To the best of | O (OR AS A CONSE O (OR | e. XICAT EQUENCE OF EQUENCE OF resulting 3 | ot enter the m ion : : : : : : : : : : : : : : : : : : | ode of dying, such ode of dying, | i Part I. 24e. I Part I. 24e. Solution of the Company of the Com | WAS AN AUTOPSY PERFORMED? EVES 2 NO NO I (Street and Number State) Bethune and menner as steplace, end due to 1 29d. DA | 24 CCURED FOR OF RUES ROAC Sted. TE Stone | Approximate interval Baty Onset and D Onse |

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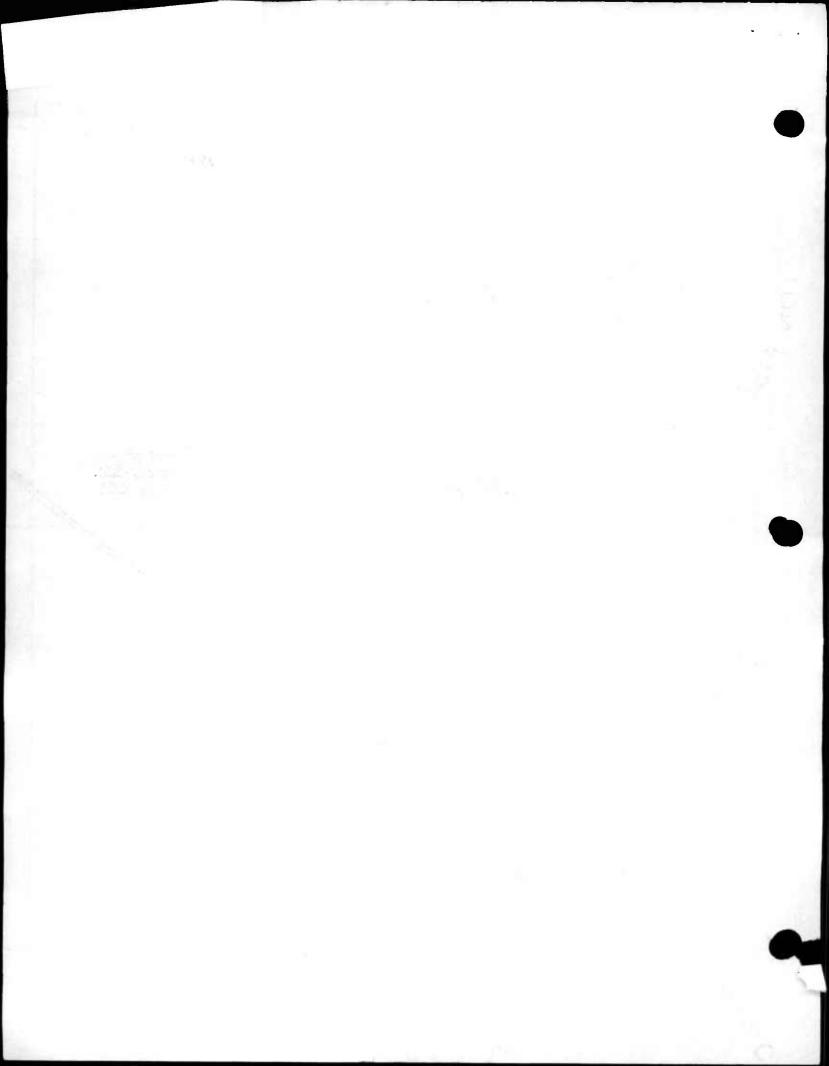
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TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| SICIAN; The law inquire many death certificate be executed within 2-3 Jours after death. Page | ECTOR: After this certificate has been altered by the production of the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | rs after death with the State Draft of Head, and Modelle the Commission, or removal. | m 28 is marked, or item 23 shows any miury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|--|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICI | TO THE FLINERAL DIRECTOR: After this cert | be filed within 72 hours after death with the | IMPORTANT: If item 28 is marked, o | |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPAR CERTIF | | | | D MEN | TAL HYGIENE REG. NO. | | | 0 14 10 |
|---|--|---|--|--|------------------------|--------------------------|---|---|---------------------|--------------------------------|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | John J. N | ligan | | | | 1M | ATE OF DEATH DAY | | AR | IME OF DEATH |
| | | 5. SEX 6. AGE (| in yrs. last birthday) YRS. | IF UNDER 1 1 | | IF UNDER 24 HR | (A | ATE OF BIRTH Horith, Day, Year) C.12,/8 | | BIRTHPLAC Country) aryla | E (State or Foreign |
| e B | 9a. FACILITY NAME (If not institution, give street of Golden Age Guest I 1442 Buckhorn Rd. RESIDENCE OF DECEDENT | | | 9b. CITY, TOWN OR LOCATION OF DEATH Sykesville | | | | | 9c. COUNTY Carro | 111 50 | |
| DIRECTOR | 10a. STATE 10b. COUNTY | | | | LOCATIO | n Randal | 1eto | NETTO | | 100 | . INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | | | | | IP CODE | | | 10g. CITIZEN | OF WHAT | |
| FUNERAL | 3707 McDonogh Road 11. Marital status 12. Was decedent ever in u.s. af | | | | | | | RIGIN? (Specify Yes | Unite | | merican Indian. |
| B | 1 Never Married 2 Married 3 Widowed 4 Divorced FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | | | | | ify Cuban, Me ☑ NO Sp | | erto Rican, etc.) | | Specify: aucas | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade or Elementary/Secondary (0-12) | ATION ompleted) College (1-4 or 5+) | 16a. DECEDENT'S (Give kind of life. Do NOT u | USUAL OCC work done du se ratired.) | CUPATION iring most | of working | | 16b. KIND OF BUS | | | |
| OMP | 8th.Grade 17. FATHER'S NAME (First, Middle, Last) | Salesma | an | | 16. MOTHER'S | NAME (F | R. V | | rris | | |
| BE C | Jo | ohn T. Migan | | | | | | ry G. G | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | Number, City or Tow | | de) | |
| | Mr. Alfred J. Hohn | | 2029 L | | | | | y, MD 21 | CATION — CIN | or Town, | State |
| | 1X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify) | val from State | other place) | Lorraine Park Cemetery Woodlawn, Maryland | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd. Randallstown, MD211. | | | | | | | | | | |
| | 23. PART i. Enter the diseases, or co shock, or heart failure. L | | | not enter t | the mod | e of dying, | such ea | cardiec or respi | ratory arrest | , | Approximete interval Between |
| | iMMEDIATE CAUSE (Final disease or condition resulting in death) | ualion | | | | | | | | Onset and Death | |
| , | DUE TO (OR AS A CONSEQUENCE OF): Ale how or he had se | | | | | | | | | | |
| ATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | A CONSEQUENCE (| OF): | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | F): | | | | | | | | | |
| CAL CE | PART II. Other significent conditions | contributing to death | but not resulting | sulting in the underlying cause given in | | | n In Part | n Part I. 24a. WAS AN AUTOPSY PERFORMED? | | AM | RE AUTOPSY FINDINGS VILABLE PRIOR TO MPLETION OF CAUSE |
| PHYSICIAN: MEDI | | | | | | | | 1 TYES 2 | ! <u> </u> NO | | DEATH? |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL/ | ACE OF DEATH | H (Check o | nly one) | | | |
| SIC | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Out | Ipatient 3 DOA | OTHER 4) Allura | | 5 🗆 Reside | nce 8 🗆 | Other (Specify) | | | |
| РНУ | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | | ME OF | 28c. INJU WOF | RIC? | | 1. DEȘCRIBE HOW | NJURY OCCU | RED | |
| ED BY | 2 Accident investigation | | | M 1 YES 2 NO | | | _ | LOCATION (Street City or Town, State | | Rural Rout | e Number, |
| COMPLET | (Critical Grity) | | | | | | due to the cause(a) and manner as stated. the time, data and place, and due to the cause(a) and a | | | nd manner on stated | |
| | 29b. SIGNATURE AND TILLE OF SCRIPPING | // | | ,,, | | 29c. LICENSE | | | , | | onth, Day, Year) |
|) BE | fatul-ti | Metup | | | | 020 | 806 | | 1 | 2/13/ | 96 |
| 10 | 30. NAME AND ADDRESS OF PERSON WHO | O COMPLETED CAUSE OF D | EATH (ITEM 27) (Ty) | 1 Geol | ty E | d | 5/0 | leasbug | Wa | 121 | 787 |
| 31. DATE FILED (MONTH), Day, Year) 32. REGISTRAR'S SIGNATURE 3. A 1000 S. L. Savidson-Rendere | | | | | | | | | / | | |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | TEGOTO TO SET TO THE CONTROL OF SET TO THE C | | | | | | | | | | | | | |
|---|--|--------------------------------|---|---------------------------------|--------------------------------|-------------------|------------|----------------------|-------------|----------------------------|--|------------|-------------------------|---|
| , | 1. DECEDENT'S NAME (First) CESAREO | | MEDR | ANO | * | | | | | 2. DATE OF DEATH DAY YEAR | | | YEAR | 3, TIME OF DEATH |
| | 4. SOCIAL SECURITY NUME | | 5. SEX | | s. last birthday) | IF UND | ER 1 YEAR | # UNDE | R 24 HRS. | 7. DATE OF BIRTH 8. BIRTH | | | PLACE (State or Foreign | |
| | 234-46-649 | 95 | 1 🗆)(2 🗆 F | 68 | YRS. | MONTHS | 1 | HOURS | MIN. | (Month, Day, Sept. | (Year) | 922 | Cult | y) |
| | 9a. FACILITY NAME (If not institution, give street and number) | | | | | 9b. CIT | Y, TOWN | OR LOCAT | ION OF DE | | - | | NTY OF DI | |
| 8 | UNION M | EMORIA | L HOSPIT | AL | | BALTIMORE | | | | | | | | |
| ទ្ធ | RESIDENCE OF DECEDENT | | | | 140-000 | N WOULD | OR LOC | 471011 | | | | | | and more every |
| DIRECTOR | Maryland | 10b. COUNTY | 1 | | | | more | | | | | | | 10d. INSIDE CITY LIMITS? |
| | 10e, STREET AND NUMBER | | - | | | | _ | of, ZIP COD |)F | | | 10g. CIT | IZEN OF W | 1 XYES 2 NO |
| FUNERAL | | nwood | Road | | | | | | 1213 | | | _ | Cuba | |
| Š | 3615 Ravenwood Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. A | | | | | 13 | | CENDENT | OF HISPAN | IC ORIGIN? (Sp | | | 14. RACE | - American Indian, |
| F | 1 Never Married 2 🔀 | | FORCES? | MAR OR DATE: | s Dyeo | | | specify Cubi | | Cuba | | 777 | Black Speci | white, atc. |
| ВУ | 3 Widowed 4 Divo | erced | | | | | | | | | | | | Wille |
| Ĕ | 15. OEC (Specify onl | EOENT'S EDU y highest grade | CATION completed) | 16 | a. DECEDENT'S (Give kind of | work don | e durina n | TION nost of work | ing | 16b. KINI | D OF BUS | INESS/IN | DUSTRY | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working Me. Do NOT use retired.) Maintenance Tech. 16b. KIND OF BUSINESS/INDUSTRY (Give kind of working) Me. Do NOT use retired.) Mechanical 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meiden Surname) | | | | | | | | | | | | | | |
| Tr. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Melden Surname) | | | | | | | | | | | | | | |
| | Cesareo Me | edrano | Caballe | ro | | | | | | | | , | Riv | ero Garcia |
| B | 19a, INFORMANT'S NAME (| Type/Print) | | | 19b. MAILIN | 3 ADDRE | SS (Street | | | Route Number, C | | | | |
| Maria C. Medrano 3615 Ravenwood Rd., Balto | | | | | | | alto. | , Md.21213 | | | | | | |
| ı | 20a. METHOD OF DISPOSIT | ION | oval from State | 206. PL | ACE OF DISPO | SITION (| Name of c | cometery, cre | matory or | | 20c. LOC | CATION — | City or To | wn, Stata |
| ł | 1 Burial 2 Teremetic 4 Donation 5 Other | | | Me | tro Cr | | | | | | Cat | ons | ville, | Maryland |
| 1 | 21. SIGNATURE OF THE THE STATE OF THE STATE | | | | | | | | | | | | | |
| | | Br | yan W. | Clary | | | | | | ryland | | | | |
| | 23. PART i. Enter the d | | complications the | | | | | | | | | | reat, | Approximata intervai Between |
| | IMMEDIATE CAUSE (FI | | List only one of | ~ · | | | | | | | | | | Onset and Daath |
| | disease or condition resulting in death) | \rightarrow | • | Neu | W Th | 000 | X | | | | | | | 12 hour |
| | | | DUE TO | ORAS A CO | NSEQUENCE O | OF): | | | | | | | | 6 days. |
| S S | Sequentially list condit | | b | O OR AS A CO | ONSEQUENCE O |)FI: | | | | | | | | 6 asys. |
| CERTIFICATION | if any, leading to imme cause. Enter UNDERLY | ING | | 0 | umon | | | | | | | | | 10 |
| 띮 | CAUSE (Disease or injute that initiated events | ary | c. DUE TO | _ | INSEQUENCE (| 4.3 | - | | - | | | | | |
| ᇤ | resulting in death) LAS | T | d | | | | | | | | | | | |
| | PART ii. Other algnifica | ent condition | ns contributing to | deeth but | not resulting | in the | undertvi | ng cause | given in | Part i 24e | . WAS AN | ALITOPSY | 24h | . WERE AUTOPSY FINDINGS |
| MEDICAL | SIN | | | | | | | | | | PERFOR | MED? | 1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | for | Com | nous C | eii | P | | - | and a | 100 | | YES 2 | KNO | | DF DEATH? |
| _ | - 407 | 7000 | NOWS C | COL | LA | | | | | _ | | | | 1 U YES 27 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. DATE OF INJURY (Month, Day, Year) 28. INJURY AT WORK? 28. INJURY AT WORK? | | | | | | | - | | | | | | | |
| Sic | EXAMINER? | | HØSPITAL: 1 Inpetient 2 | ☐ ER/Outpatio | ent 3 🗆 DOA | OTHI | | ome 5 🗆 F | Residence | 8 Other (Sp | ectly) | | | |
| 훉 | 27. MANNER OF DEATH | | 28a. DATE O | F INJURY Day, Year) | 28b. TII | ME OF | | NJURY AT | | 28d, DESCRIE | BE HOW IN | NJURY O | CCURED | |
| BY | 1 Natural 5 2 Accident | Pending Investigation | , | | | М | | | □ NO | | | | | |
| 03 | 3 Suicide 8 Homicide | Could not be determined | | OF INJURY — , etc. (Specify) | At home, farm, | street, fo | actory, of | fice | | 281. LOCATIO City or To | N (Street a wn, State) | and Numbe | er or Rural I | Route Number, |
| E | | - Contention of | | | | | | | | | | | | |
| 릴 | Torroom ormy | | ICIAN: To the best o | | | | | | | | | | | |
| COMPLET | 2 MEC | DICAL EXAMINI | ER: On the basis of | examination a | nd/or investigat | ion, in m | y opinion | , death occ | ured at the | time, data and | placa, and | d dua to t | the cause(a | a) and manner as stated. |
| BE | 296 SIGNATURE AND TITLE | E OF CERTIFIE | B. | man | | | | 29c. LIC | CENSE NUN | MBER | 0 | 29d. DA | TE SIGNED | (Month, Day, Year) |
| စ္ | - and | nach | wen- | 1111) | | | | 1112 | 4389 | 46C1 | er | | 12 | 113/90 |
| | Dance | Marki | MC/M | QUI | E UM | e, Print) ULRS | rity | Av | e. U | NION 1 | Men | love int | Ho | Balt, Md. |
| | 31. DATE FILED (Month, Day, | | 32. REGISTR | AR'S SIGNATU | | | | | , | | | | - | |
| | /2/13 / /R | r.14 | 1990 4 | the Devi | Sen-Par | NA. | | | | | | | | |

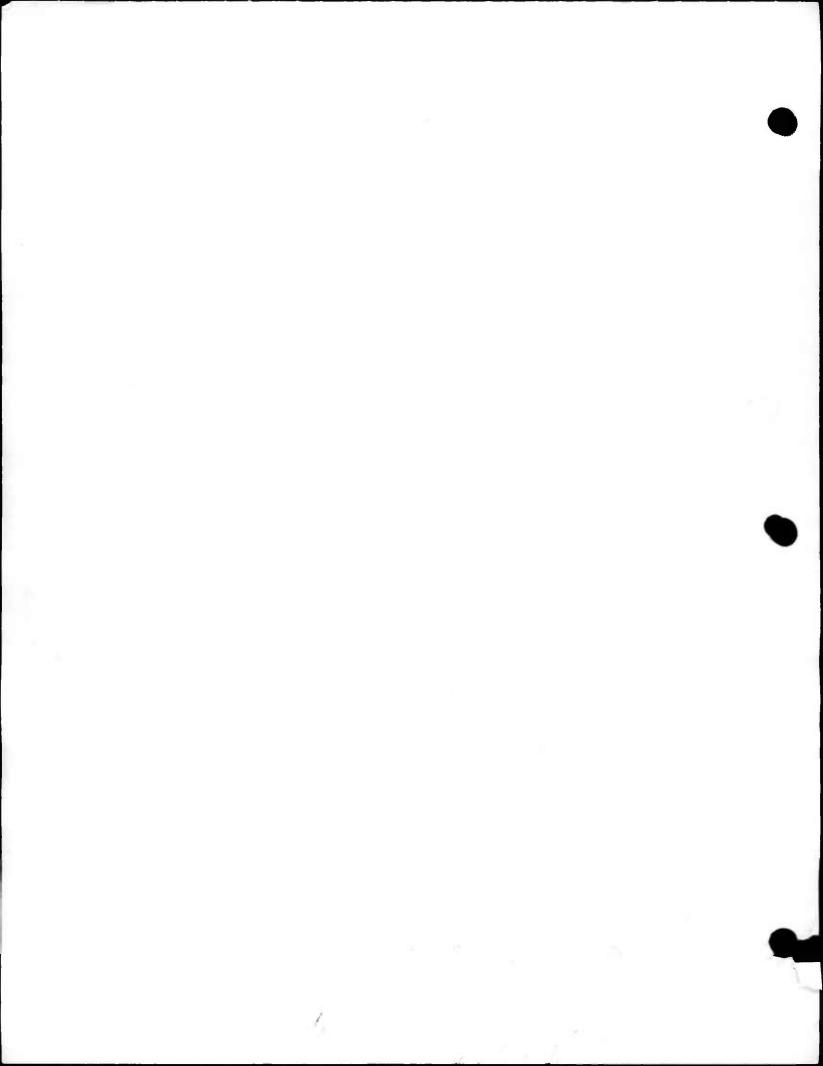
hospital or attending physician. Aached for use as the burial-transit permit, Pages 1, 2, 3 should BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2% after death. Page 6 may be TO THE FUNERAL DIFFCTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be flied within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be no

DHMH-16 Rev 1/89



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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | K | 13 |
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The William III of the certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has their director, the attending physician and completely be filed within 72 hours after death with the State Dept. of resources. |
| | 0 | 2 2 |
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IMPORTANT: If item 28 is marked, or item 23 mm

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

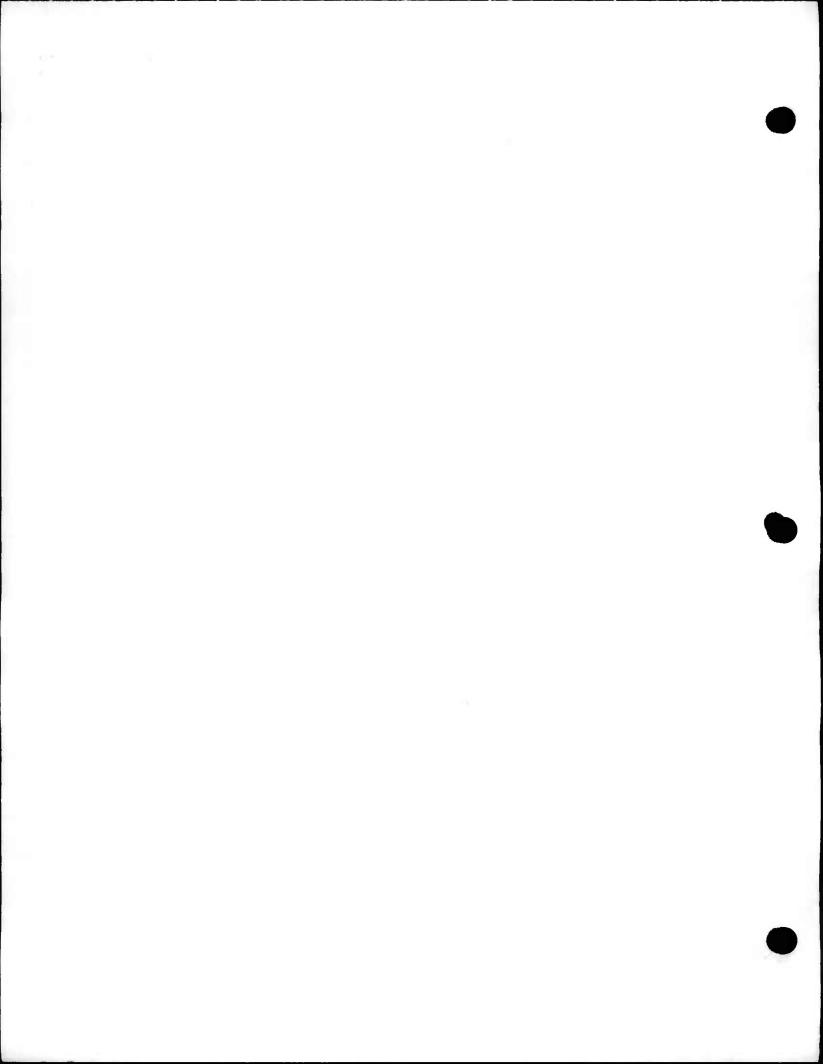
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 2. DATE OF DEATH MONTH DAY | 3. TIME OF DEATH | | | | | | |
|---|---|--|--|--------------------------------------|--|--|--|--|--|--|
| V | Ruth Lee Maules 12-10-906: | | | | | | | | | |
| | | F UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. BIRTHPLACE (State or Foreign | | | | | | |
| 4 | 116-09-4644 1 M 2 8F Q 4 YRS. | ONTHS DAYS HOURS MIN. | (Month, Day, Year) 4-19-1896 | Country) Marvland | | | | | | |
| | 216-09-46-44 1 M 2 F 94 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) Country) 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | |
| FUNERAL DIRECTOR | Baltimore County General Hospital Randallstown Baltimore | | | | | | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | |
| E | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | |
| - | Maryland Baltimore County Pikesville 100. STREET AND NUMBER 109. CITIZEN OF WHAT | | | | | | | | | |
| RA | 220 Sudbrook Lane | 21208 | | | | | | | | |
| N. | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED | 13. WAS DECENDENT OF HISPAN | US IC ORIGIN? (Specify Yea or No.— | A 14. RACE — American Indian, | | | | | | |
| | 1 Never Married 2 Married FORCES? 1 YES 2₹□NO IF YES, GIVE WAR OR DATES | If yes, specify Cuben, Mexicar 1 YES 2X XNO Specify | , Puerto Rican, etc.) | Black, White, atc. Specify: | | | | | | |
| BY | 3 🔀 Wildowed 4 🗌 Divorced | 1 2 22 22 22 23 | | White | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 10a. DECEDENT'S U (Give kind of wo | rk done during most of working | 18b. KIND OF BUSINESS/IN | DUSTRY | | | | | | |
| 91 | Elementary/Secondary (0-12) College (1-4 or 5+) | retired.) | | | | | | | | |
| MP | 8th Grade Homemak | er | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | WE (First, Middle, Malden Sumama) | | | | | | | |
| BE | Charles Bernard Weigel | | Schoflen | | | | | | | |
| 2 | | DDRESS (Street and Number of Rural F | | | | | | | | |
| | | lbrook Lane Pil | | | | | | | | |
| | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Other place) | ION (Name of cemetery, crematory or | ł . | - City or Town, State | | | | | | |
| 4 | 4 Donetion 5 Other (Specify) Druid Rid | ge Cemetery | | esville, MD | | | | | | |
| | Ingest C. W. Ka Olas of | Loring Byers Funeral Directors, Inc. | | | | | | | | |
| | Joseph S. W. Kellner | 8728 Liberty H | | | | | | | | |
| | 23. PART I. Enter the disesses, Dr complications that caused the death. Do no abock, Dr heart failure. List only one cause on each line. | t enter the mode of dying, such | ss cardiac or respiratory en | | | | | | | |
| | IMMEDIATE CAUSE (Final | | | | | | | | | |
| | disease or condition | | | | | | | | | |
| | resulting In deeth) a. Renal Fallure DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| Z | Sequentially list conditions, Due TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| E | if sny, leeding to immediate | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or Injury Due TO (OR AS A CONSEQUENCE OF) | nicel Inten | Ltion | | | | | | | |
| | that initiated events reculting in desth) LAST | | | į | | | | | | |
| Ü | d | | | | | | | | | |
| 4 | PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? AWAILABLE PRIDE TO | | | | | | | | | |
| MEDICAL | Lores Lucias Abelicateur | | | | | | | | | |
| Æ | 1 TES 2 NO OF DE | | | | | | | | | |
| | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | 26. PLACE OF DEATH (Che | ock only one) | | | | | | | |
| SI | MOSE IAC. | OTHER: | 8 Other (Specify) | | | | | | | |
| F | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) INJU | OF 28c, INJURY AT WORK? | 28d. DESCRIBE HOW INJURY OF | CCURED | | | | | | |
| ВУ | 1 Netural 5 Pending 2 Accident Investigation | M 1 YES 2 NO | | | | | | | | |
| | 3 Suicide s Could not be 28a. PLACE OF INJURY — At home, farm, at building, atc. (Specify) | eet, factory, office | 281. LOCATION (Street and Number City or Town, State) | er or Rural Route Number, | | | | | | |
| ETE | 4 Homicide determined | | | | | | | | | |
| PL | 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred | at the time, data and place, and dua | to the cause(a) and manner as st | nted. | | | | | | |
| 29e. CERTIFIER (Chock only one) 29e. CERTIFIER (Chock only one) 29e. MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIER | 29c. LICENSE NUN | IBER 29d. DA | TE SIGNED (Month, Day, Year) | | | | | | |
| 00 | allow I chiveren m | 0 029 | 08-5 | 12 -10 -90 | | | | | | |
| 7 | 9 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | |
| | The same and about 30 or Penson who completed cause of Death (Hem 27) (1/90), | | | | | | | | | |
| | | , | | | | | | | | |
| | Allan J. Chineus M. D 31. DATE FILED (Morth, Dey, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | |
| | | | | | | | | | | |

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TO BE COMPLETED BY | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|--|--|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| al, | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| he funeral director, page 5 should be detached for use as the bu | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bu |
| r death. Page 6 may be retained by the hospital or attending ph | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 and after death. Page 6 may be retained by the hospital or attending ph |
| | |

| | FOR STATE REGISTRAR | STATE OF MARYL | LAND / DEPARTM CERTIFIC | | | IENTAL HYGIENI REG. NO. | E | |
|------------------------------------|--|--|--|---|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1 01 | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | Edwin B. Miles | | | | - 1 | MONTH DA | 13 9 | |
| ı | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. B | RTHPLACE (State or Foreign |
| | 215-09-9554 9e. FACILITY NAME (If not institution, give: | | 35 YRS. | NTHS DAYS | HOURS MIN. | 7-30-05 | M | aryland |
| - | | | 90 | | R LOCATION OF DEA | ATH | 9c. COUNTY | OF DEATH |
| 2 | St. Agnes Hospit | :aı | | ва | 1timore | | | |
| DIRECTOR | 10e. STATE 10b. COUNT | | 10c. CITY, TO | OWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| 5 | Maryland | | Ва | altimor | e | | | 1 X YES 2 NO |
| ¥ | 10e. STREET AND NUMBER 10f. ZIP CODE | | | | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| DI LUNEHAL | 2217 Ashton Stre | et | | | 21223 | | U.S | .A. |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YES | IN U.S. ARMED | | ENDENT OF HISPANI city Cuben, Mexicen | C ORIGIN? (Specify Yee Puerto Rican, etc.) | or No- 14. F | RACE — American Indien, Black, White, atc. |
| | 1 Never Married 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WAR OR I | DATES | | 2 NO Specify: | | | Specify: |
| | 15, DECEDENT'S EDU | ICATION | 18e. DECEDENT'S USI | IIAL OCCUPATIO | ·M | 16b. KIND OF BUS | INESC/INDUSTS | White |
| <u> </u> | (Specify only highest grade | e completed) | (Give kind of work | done during more | st of working | 160. KIND OF BUS | INCOS/INDUS I | 11 |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Chauffe | enr | | Corkran | H+11 | |
| COMPLE | 17. FATHER'S NAME (First, Middle, Last) | | _ Ollaull (| -ur | 18. MOTHER'S NAM | ME (First, Middle, Maiden | | |
| | Thomas Miles | | | | | M. Barnes | | |
| # F | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | | oute Number, City or Town | | e) |
| 2 | Edwin H. Miles | | 2217 As | shton S | treet B | altimore, | MD 212 | 23 |
| | 20e METHOD OF DISPOSITION | 20 | b. PLACE OF DISPOSITION | | | | CATION - City | |
| | 4 Donation 5 Other (Specify) | noval from State | other place) Loudon Parl | k Cemet | ery | Balt | imore, | MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | | | D ADDRESS OF FAC | HLITY | | |
| - 1 | > Mum 20 | Finhen | | Hubbar | d Funera | 1 Home, Ir | ıc. | WD 01000 |
| 4 | 23. PART I. Enter the diseases, or | complications that cause | ed the death. Do not | | | ve. Balti | | Approximate |
| | shock, or heert fallure. | Liet only one ceuse on | | | ao o aying, coo | au outdido or roupi | atory arroat, | interval Between Onset and Death |
| | IMMEDIATE CAUSE (Final disease or condition | 110 | 16 ina l | 1 | and E | 1. 1.1. | | Onset and Death |
| | resulting in death) | resulting in death) a | | | | | | |
| , | disease or condition resulting in death) a. Massive fulmoney Chubolism Due to (or as a consequence of): Output Delp Vensus Humbosis | | | | | | | |
| 5 | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE OF): | 1700 | 774007-3 | | | |
| CERTIFICATION | cause. Enter UNDERLYING | C. | | | | | | |
| | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | NSEOUENCE OF): | | | | |
| | resulting In deeth) LAST | | | | | | | 1 |
| 7 11 | | d | | | | | | |
| - 14 | PART II. Other significant condition | ns contributing to death | but not resulting in t | he underlying | cause given in i | Part I 24e WAS AN | AUTOPSV | 24h WEDE AUTOPSY FINDINGS |
| 3 | PART II. Other algnificant condition | | | the underlying | g cause given in i | PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 3 | ^ / | | but not resulting in t | the underlying | g cause given in i | Part I. 24e. WAS AN PERFOR 1 TYES 2 | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 3 | ^ / | | | the underlying | g cause given in i | PERFOR | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE |
| F | Pulh | | | | | PERFOR | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| F | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | w śń | 26. PL | ACE OF DEATH (Che | PERFOR 1 VES 2 | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 3 | Pulh 25. WAS CASE REFERRED TO MEDICAL | HOSPITAL: 1 Inputlent 2 ER/Ou 20e. DATE OF INJURY | tipetient 3 DOA 4 | 26. PL PTHER: Nursing Hom F 26c. INJ | ACE OF DEATH (Che | PERFOR 1 YES 2 bck only one) a Other (Specify) | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| FITTSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Inpetient 2 ERVOu 26e. DATE OF INJURY (Month, Dey, Veer) | tipetient 3 DOA 4 | 26. PL THER: Nursing Hom F 28c. INJ WO | ACE OF DEATH (Che | PERFOR 1 VES 2 | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DI PRISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | HOSPITAL: 1 Inpetient 2 ER/Ou 26e. DATE OF INJURY (Month, Day, Year) | tpetient 3 DOA 4 28b. TiME 0 INJUR Y — At home, farm, stre | 26. PL PTHER: Nursing Hom DF Y WO 1 1 | ACE OF DEATH (Che e 5 Residence URY AT RK? | PERFOR 1 YES 2 bck only one) a Other (Specify) 28d. DE\$CRIBE HOW II | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DI PRISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | HOSPITAL: 1 Inputlent 2 ER/Ou 26e. DATE OF INJURY (Month, Day, Year) | tpetient 3 DOA 4 28b. TiME 0 INJUR Y — At home, farm, stre | 26. PL PTHER: Nursing Hom DF Y WO 1 1 | ACE OF DEATH (Che e 5 Residence URY AT RK? | PERFOR 1 YES 2 pick only one) a Other (Specify) 28d. DESCRIBE HOW II | MED? | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DI PRISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER 1 CERTIFYIMS DAYS | HOSPITAL: 1 Inpetient 2 ERVOu 26e. DATE OF INJURY (Month, Dey, Veer) 28e. PLACE OF INJUR building, etc. (Sp | tpetient 3 DOA 4 28b. TiME 0 iNJUR TY — At home, farm, streecity) | 26. PL DTHER: Nursing Hom DF 26c. INJ WO 1 | ACE OF DEATH (Che 5 Residence URY AT RK7 (ES 2 NO | PERFOR 1 YES 2 Other (Specify) 28d. DESCRIBE HOW II City or Town, State) | NJURY OCCURE | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| DI PRISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be 4 Homicide determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS) | HOSPITAL: 1 Inpetient 2 ERVou 26e. DATE OF INJURY (Month, Day, Year) 26e. PLACE OF INJUR building, etc. (Sp | tipetient 3 DOA 4 28b. TIME 0 INJUR TY — At home, farm, streecity) | 26. PL DTHER: Nursing Hom DF 28c. INJ WO 1 1 1 | ACE OF DEATH (Che 5 Residence URY AT RK? /ES 2 NO end place, end due | PERFOR 1 YES 2 Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street & City or Rown, State) to the cause(e) end mer | MED? NO NJURY OCCURE | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | HOSPITAL: 1 Inpetient 2 ER/Ou 26e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, etc. (Sp | tpetient 3 DOA 4 28b. TIME 0 INJUR TY — At home, farm, streedly) wiedge, death occurred a | 26. PL THER: Nursing Hom NF Y M 1 1 1 Net, factory, office at the time, date In my opinion, d | ACE OF DEATH (Che 5 Residence URY AT RK? VES 2 NO e end place, end due eath occured at the | PERFOR 1 YES 2 a Other (Specify) 28d. DESCRIBE HOW II City or Town, State) to the cause(e) end mer time, dete and piece, en | MED? NO NJURY OCCURE and Number or R iner as stated, d due to the ce | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dural Route Number, |
| COMPLETED BY PHISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be 4 Homicide determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYS) | HOSPITAL: 1 Inpetient 2 ER/Ou 26e. DATE OF INJURY (Month, Dey, Year) 28e. PLACE OF INJURY building, etc. (Sp | tipetient 3 DOA 4 28b. TIME 0 INJUR TY — At home, farm, streecity) | 26. PL THER: Nursing Hom NF Y M 1 1 Neet, factory, office at the time, date | ACE OF DEATH (Che 5 Residence USY AT RK7 FES 2 NO end place, end due eath occured at the | PERFOR 1 YES 2 a Other (Specify) 28d. DESCRIBE HOW II City or Town, State) to the cause(e) end mer time, dete and piece, en | MED? NO NJURY OCCURE and Number or R iner as stated, d due to the ce | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D D D D D D D D D D D D D |
| BE COMPLETED BY PRISICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide 6 Could not be 4 EXTIFIER (Check only 1 CERTIFYING PHYS 070) 2 MEDICAL EXAMIN | HOSPITAL: 1 Inpatient 2 ERVOu 26e. DATE OF INJURY (Month, Dey, Veer) 28e. PLACE OF INJURY building, etc. (Sp | tpetient 3 DOA 4 28b. TiME 0 INJUR TY — At home, farm, streecily) wiedge, death occurred a ion and/or investigation, if | 26. PL THER: Nursing Hom FF 28c. INJ WO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ACE OF DEATH (Che 5 Residence URY AT RK? FES 2 NO end place, end due eath occured at the 29c. LICENSE NUM AS 243 | PERFOR 1 YES 2 a Other (Specify) 28d. DESCRIBE HOW II 28f. LOCATION (Street & City or Town, State) to the cause(e) end mer time, dete and piece, en | MED? NO NJURY OCCURE and Number or R iner as stated, d due to the ce | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Dural Route Number, |
| _ 14 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | HOSPITAL: 1 Inpatient 2 ERVOu 26e. DATE OF INJURY (Month, Dey, Veer) 28e. PLACE OF INJURY building, etc. (Sp | tpetient 3 DOA 4 28b. TiME 0 INJUR TY — At home, farm, streecily) wiedge, death occurred a ion and/or investigation, if | 26. PL DTHER: Nursing Hom DF 28c. INJ WO 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ACE OF DEATH (Che 5 Residence USY AT RK7 FES 2 NO end place, end due eath occured at the | PERFOR 1 YES 2 VES 2 VES | MED? NO NJURY OCCURE and Number or R iner as stated, d due to the ce | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO D D D D D D D D D D D D D |

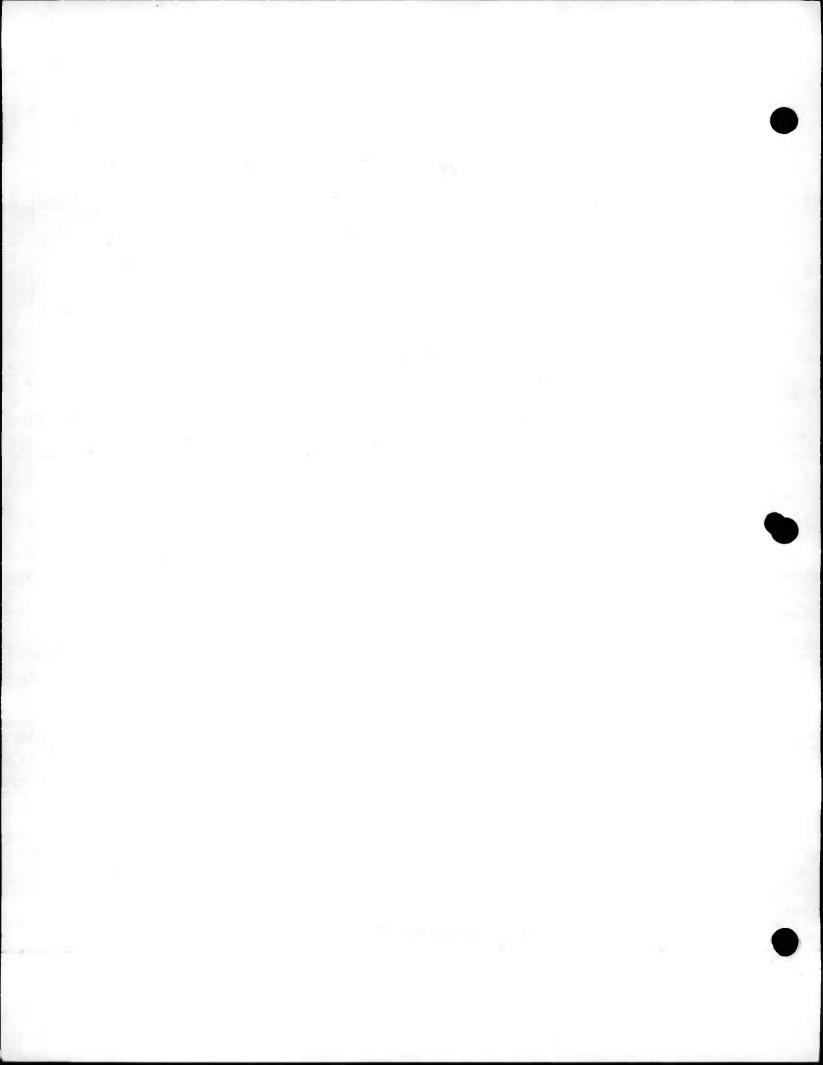




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| DIVISION | |
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| HYSICIAN: The law requires that the death certificate be executed within z is after death. Page 6 may be retained by the hospital or attending physician. | his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should with the State Dent, or Health and Mental Hydiene prior to burial, cremation, or removal. | irked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|--|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physic had writin 72 hours after death with the State Dent. of Health and Mental Motilete or | Ë |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | DEPARTMENT OF | | MENTAL HYGIEN | | | | |
|------------|---|--|--------------------------------|--|--|--|-----------------------|--|----------------|
| | 1. OECEDENT'S NAME (First, Middle, Last) ELERWEASE | . MAYNOR | | | 2. DATE OF DEATH MONTH D | | AR 3. T | IME OF DEATH | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (In yrs. II | est birthday) IF UNDER 1 YEA | | 7. DATE OF BIRTH | 8. 0 | BIRTHPLAC | E (State or Foreig | gn |
| | 215-12-0760 | 1 1 2 F | YRS. MONTHS DAY | S HOURS MIN. | (Month, Day, Year) | 14 | SIC | · . | |
| | 9e. FACILITY NAME (If and institution, give street end number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | |
| 5 | RESIDENCE OF DECEDENT | -di | | Silla | , | | | L | |
| DIRECTOR | 10e. STATE TOb. COUNT | Y | 10c. CITY, TOWN OR LO | CATION | | | | INSIDE CITY | |
| | 10e. STREET ANO NUMBER | | 1300 | 10f. ZIP COOE | | 10g. CITIZEN | - | YES 2 NO | |
| ER | | jolet ane | • | 2121 | 5 | 2 | ·C | - | |
| BY FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. A FORCES? 1 YES 2 | | DECENDENT OF HISPAN , specify Cuben, Mexice | IIC ORIGIN? (Specify Years) | - | RACE - A Bleck, Wh | Americen Indien, ite, etc. | |
| 2 | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | YES 2 NO Specify | | | Specify | 600 | , |
| | 15. DECEDENT'S EDU (Specify only highest grade | | DECEDENT'S USUAL OCCUP | ATION | 16b. KIND OF BU | SINESS/INDUST | TRY | JICO | \dashv |
| COMPLEIED | Elementary/Secondary (0-12) | | fe. Do NOT use retired.) | THOSE OF WORKING | | | | | |
| MF | ST. FATHER'S NAME (First, Michile, Last) | | Henseure | V | ME (First, Middle, Maiden | 0 | | | - |
| | Clie Duna | nt. | // | 16. MOINER'S NA | ME (PIS), MIGDIO, MILOUR PLA Person d | MAI! | a | Pour | _ } |
| O BE | THE INFORMANT'S NAME (TypesPrint) | 1. 11 | LING ADDRESS (Stre | et end Number or Rural I | Routa Number, City or Tow | n, State, Zip Cod | de) | 4004 | $\tilde{\neg}$ |
| - | Honice Mes | get | 2823 | | 1 AVE 1 | 3110 | n | 11212 | 205 |
| 1 | 20s. MEPTOD OF DISPOSITION Surfal 2 | noval from State 20b. PLAC | E OF DISPOSITION (Name of | cemetery, crematory or | 0 20c. LC | CATION - City | or Town, S | State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSEE | 22. NAM | E AND ADDRESS OF FA | CILITY | mus | m | 4 | \dashv |
| } | * Bott C | and Home | 11 | 1126 | N Co | 05 | 16 | 1 | - 1 |
| ٦ | 23. PART I. Enter the diseases, or | complications that caused the | death. Do not enter the | mode of dying, suc | h as cardiac or reap | Iratory arreat | | Approximate | |
| | ahock, or haart fallure. IMMEDIATE CAUSE (Final | List only one cause on each list | ne. | | | | | Onset and D | |
| | disease or condition resulting in death) | | -monory | MRREST | | | | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | |
| HIFICATION | Sequentially list conditions, if any, leading to immediate | b. OVE TO (OR AS A CONS | | iel Di | sense | | | | \dashv |
| 3 | cause. Enter UNDERLYING CAUSE (Disease or Injury | * | 7 OF P | DIMONA | RY SUMP | mi | | | |
| ₿ | that initiated events resulting in death) LAST | DUE TO (OR AS A CONS | EQUENCE OF): | | | | i | | - 1 |
| | | d | | | | | | | |
| AL | | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. | | | | 24e. WAS AN AUTOPSY 24b. PERFORMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| MEDIC | Hypertenton | | | 1 TYES | 1 L YES 2 NO OF | | DEATH? | - 1 | |
| Σ. | | | | | | | 1 TES 2 NO | | |
| IA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | B. PLACE OF DEATN (Ch | eck only one) | | | | |
| PHYSICIAN: | 1 YES 2 NO | HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient | | Home 5 - Residence | | | | | |
| F | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Near) 28b. TIME OF 28c. INJURY AT 28d. OESCRIBE NOW INJURY OCCURED (Month, Day, Near) 1 Natural 5 Pending | | | | | | - 1 | | |
| 184 | 2 Accident Investigation 3 Suicide 6 Could not be | 289. PLACE OF INJURY — At home, farm, street, factory, office 281. LOC | | | | CATION (Street and Number or Rural Route Number, | | | |
| | 4 Homicide determined | building, etc. (Specify) | | | | City or Town, State) BRELW STREET | | | |
| 7 | 290. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my knowledge, | death occurred at the time, | date end place, end due | to the cause(e) end mi | nner as stated. | | | |
| COMPLETED | one) 2 MEDICAL EXAMIN | ER: On the basis of examination end/o | or Investigation, in my opinio | on, death occured at the | time, date and place, e | nd due to the c | ause(s) an | d manner as sta | ted. |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIFIE | IR \ | | 29c. LICENSE NU | 29c. LICENSE NUMBER 29d. (| | | nth, Day, Year) | |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DEATH OF | TEM 27) (Survey Brigar) | | | L VA | 410 | en U | _ |
| | UNIVERS | ily of my | RYLAND . | HORDITA | 7 | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNAPURE | han Randall | | | | | | \dashv |
| - 1 | 12/10/54性による | r INTIL American | - | | | | | | |

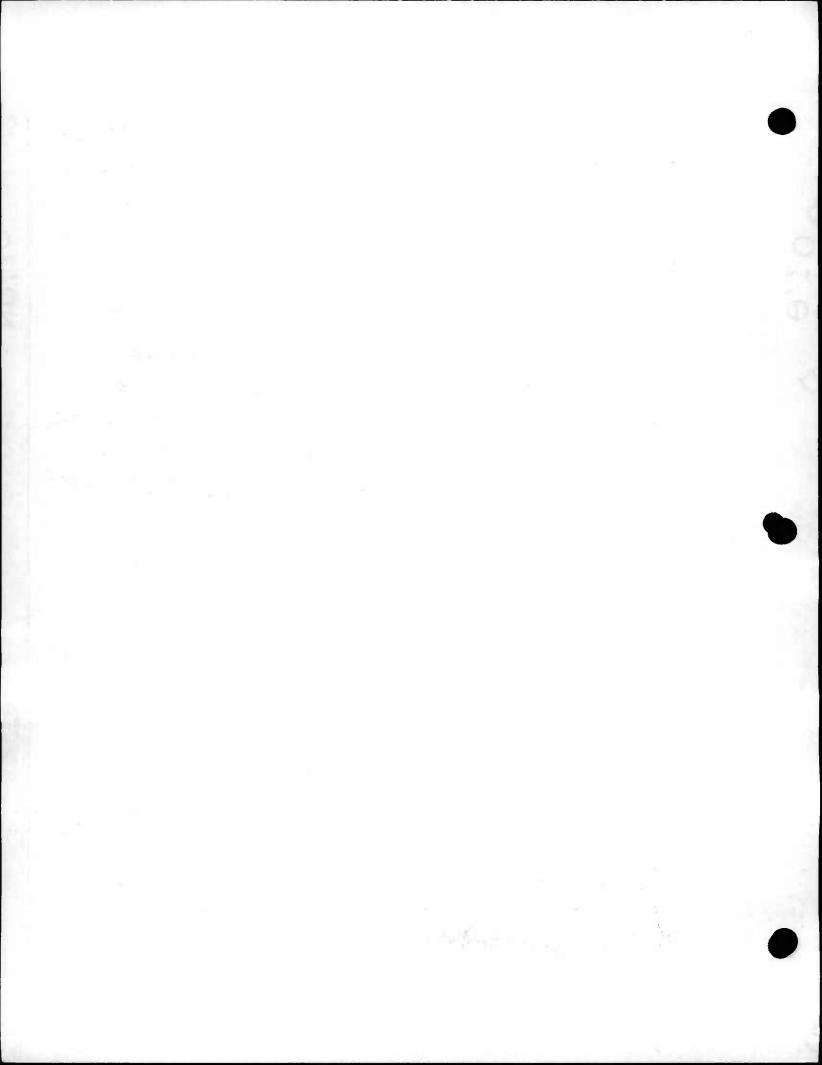


| 4YSICIAN: The law requires that the death certificate be executed within 2. mans after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should nit the State Dent, of Health and Mental Hodiene prior to burial, cremation, or removal. | rited, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exe | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician an he sided within 22 hours after death with the State Deot, of Health and Mental Hydiene prior to the | PORTANT: If item 28 is marked, or item 23 shows any injury, or other trauma |
| TO THE HO | TO THE FU | IMPORTA |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| F | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF | | MENTAL HYGIENI REG. NO. | E | | |
|----------------|---|---|---------------------------------|----------------------------------|------------------------|----------------------------|-------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Mark | Ε. | | Medley | | 2. OATE OF DEATH DA | Y YEA | 3. TIME OF DEATH | |
| - 8 | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. B | IRTHPLACE (State or Foreign | |
| 18 | 212-80-7997 | 1 -M 2 □ F | 29 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | 0 | ountry) | |
| | 9e. FACILITY NAME (If not institution, give | | 29 | 9h CITY TOW | OR LOCATION OF D | 103 03 | 61 | MARYLAND | |
| œ | | | | | | | | | |
| 5 | North Arundel F | lospital | | I GI | <u>en Burnie</u> | 2 | Anne | Arundel | |
| 2 | 10s. STATE 10b. COUNT | | 10c. C/1 | Y, TOWN OR LOC | ATION | | | 10d. INSIDE CITY | |
| DIRECTOR | MARYLAND | ANNE ARUND | er l | 5 | EVERN | | | LIMITS? | |
| | 10e. STREET AND NUMBER | | | | of, ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| 2 | 1336 SLEEPY H | OLLOW ROAD | | | 21144 | | TI | S.A. | |
| FUNERAL | 11. MARITAL STATUS | 12 WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS D | CENGENT OF HISPA | NIC ORIGIN? (Specify Yee | | RACE — Americen Indien, Black, White, etc. | |
| | 1 Never Merried 2 Merried | FORCES? 1 YES | 2-7 NO | If yes, | | n, Puerto Rican, etc.) | | | |
| B | 3 Widowed 4 Divorced | ir res, dive men on t | AIES | 10. | :9 2 [2840 Specif | у. | | WHITE | |
| | 15, OECEOENT'S EDI | JCATION | 16e. DECEDENT'S | | | 18b. KINO OF BUS | SINESS/INOUSTI | RY | |
| | (Specify only highest grad Elementery/Secondary (0-12) | College (1-4 or 5+) | (Give kind of life. Do NOT u | work done during se retired.) | nost of working | | | | |
| 립 | 8 | _ | CARP | ENTER | | CON | TRACT | ORS | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Melden | Surname) | | |
| | NORMAN C. | MEDLEY | | | DOROT | HY T. | COLL | INS | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | t and Number or Rural | Route Number, City or Town | n, State, Zip Cod | 0) | |
| 2 | REGINA T. | MEDLEY | 1336 | SLEEF | Y HOLLO | W ROAD, SE | EVERN. | MD. 21144 | |
| | 20e. METHOD OF DISPOSITIO | 20 | | | cemetery, crematory or | | CATION — City | | |
| | 1 Buriel 2 Tremation 3 Red 4 Donation 5 Other Decily) | noval from State | METRO C | REMATO | RY, INC. | CAT | ONSVI | LLE, MD. | |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENS 64 | 1 | | ANO AOORESS OF FA | | | | |
| | · Nary | d. Lou | fmans | RAYM | OND C. | FINK FUNE | ERAL H | OME 21061 | |
| | 4 | | 0 - | | | WY.S.W.GI | | RNIE, MD. | |
| | 23. PART I. Enter the diseases of ahock, or heert fallure | complications that cause . List only one cause on | d the deeth. Do | not enter the a | node of dying, au | ch ea cerdlec or respi | ratory erreet, | Approximete Interval Between | |
| | IMMEDIATE CAUSE (Final | • | | j. | | | | Onset and Deeth | |
| | disease or condition resulting in death) | . Thoracic | Trauma | | | | | | |
| | | DUE TO (OR AS | A CONSEQUENCE C | OF): | | | | | |
| Z | Sequentially list conditions, | b | | | | | | | |
| Ĕ | if any, leading to immediate | DUE TO (OR AS | A CONSEQUENCE (| DF): | | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or injury | C | A CONSEQUENCE O | | | | | | |
| 빌 | that initiated events reaulting in death) LAST | DUE TO (OR AS | A CONSEGUENCE C | /F): | | | | | |
| CERTIFICATION | | d | | | | | | | |
| | PART II. Other aignificent condition | one contributing to death | but not reaulting | in the underly | ing ceuse given in | | | 24b. WERE AUTOPSY FINDINGS | |
| ICAL | | | | | | PERFOR | 107 | AMILABLE PRIOR TO COMPLETION DF CAUSE | |
| 0 | | | | | | XX YES 2 | | OF DEATH? XIX YES 2 □ NO | |
| 2 | | | | | | | | XX 153 2 □ 110 | |
| PHYSICIAN: MED | 25. WAS CASE REFERRED TO MEDICAL | T | | 26 | PLACE OF DEATH (C | heck only one) | | | |
| S | EXAMINER? XX YES 2 \(\square\) NO | HOSPITAL: 1 ☐ Inpatient 2 X ER/Ou | testlest 3 DOA | OTHER: | | | | | |
| ¥ | 27, MANNER OF DEATH | 260. DATE OF INJURY | | | ome 5 - Residence | 28d, OESCRIBE HOW | INJURY OCCUR | ED | |
| | 1 Natural 5 Pending | (Month, Day, Year) | II. | JURY 4 | WORK? | driver i | n auto | fixed object | |
| E E | 2 Accident Investigation | 26e. PLACE OF INJUE | 1 2 2 | TOPM | | 2ef. LOCATION (Street | | | |
| 입 | 3 Suicide 6 Could not be 4 Homicide determined | building, etc. (Sp | ecify) | and on the other party | | City or Town, State; |) | OCCUPATION OF THE PROPERTY OF | |
| COMPLET | 29e. CERTIFIER | | road | at the event | ecov and the first | | | th of Oak Lan | |
| MP | (Check only 1 CERTIFYING PHY | SICIAN: To the best of my kno | | | | | | | |
| 000 | A | NER: On the basis of examinat | on end/or investigat | ion, in my opinio | , geath occured at th | e time, date and place, el | na due to the co | ouse(e) end manner et Mitted. | |
| BE (| 296. SIGNATURE AND TITLE OF CENTER | | | | 29c. LICENSE NU | JMBER | 29d. DATE SI | GNEO (Month, Day, Year) | |
| 10 B | MADY | XX | | | OCM | E | 12 | 2-9-90 | |
| F | 30. NAME AND ADDRESS OF PERSON V | | | | | | | | |
| | Arin M. Dixon, | M.D. | 111 | Penn St | ., Balto. | , Md. 212 | 01 | | |
| | 31. DATE FILED (Month, Day, 'Vear)' | 32. REGISTRAR'S SIG | NATURE | | | | | | |
| | | # WF D A /A | | | | | | | |





FOR STATE REGISTRAR

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| | | 1. DECEDENT'S NAME (First, Mic | ddle, Last) | Cha | rle | s P | aul | Mur | p hy' | 7, J: | c. | 2. DATE | OF DEATH | Y | YEAR 3. | TIME OF DEATH |
| | | CHARLES 4. SOCIAL SECURITY NUMBER | | MURPH 5. SEX | | (In yrs. las | t histodoui | IE INIDE | R 1 YEAR | I I IMPE | R 24 MRS. | 7 DATE | OF BIRTH | 2 4 | O c | CE (State or Foreign |
| | | 212-07-9586 | 4 | 1X M 2 F | G. MOR | 73 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Mon | n, Day, Year) -25-1 | 017 | Country) | The second second |
| pjnovjs | | 9a. FACILITY NAME (If not institu | | eet and number) | | | _ | 9b. CIT | Y, TOWH | OR LOCAT | ION OF DI | | -27-1 | | Y OF DEAT | |
| ro . | 5 | THE WORLD THE WOOD TOOL | | | | | | - | *** | TMO | D TO C | TMV | | | | |
| 1, 2, | 5 | RESIDENCE OF DECEDENT | | | | | | | | OMI | CE C | 111 | | | | MILINES Execution |
| iit. Pages | FUNERAL DIRECTO | Maryland 10 | Ba | altimor | e | | 10c. CI | Cat | | svil | Le | | | | | d. INSIDE CITY LIMITS? YES 2 NO |
| physician. burial-transit permit. Pages | | 315 Ingleside Avenue | | | | | | | 1 | 21 2 | 228 | | | 10g. CITIZI | | T COUNTRY? |
| ding physician. the burial-tran | B | 11. MARITAL STATUS 1 X Never Married 2 Mai 3 Widowed 4 Divorces | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES | 2 1 | MED Ю | 13. | If yes, s | | en, Mexica | n, Puerto | N? (Specify Yes Rican, etc.) | or No— 1 | 4. RACE — Black, W Specify: | American Indian, hita, atc. White |
| the hospital or attending detached for use as the once. | PLETED | 15. DECEDE (Specify only his Elementary/Secondary (0-12) 12th | | ATION completed) College (1-4 or 5 | +) | (G life. | Do NOT u | work done se retired.; | during ri | nost of work | ing | | Merch | | | nes |
| | E COMPL | 17. FATHER'S NAME (First, Middle Charles Pa | | Murphy. | Sr | | | | | 18. MOT | | ME (First, | Middle, Maiden | | | |
| 6 may be retained by ctor, page 5 should be must be notitled at | TO B | 19a. INFORMANT'S NAME (Type) Mary M. Di | Print) | | | | | | | and Numbe | er or Rural | Floute Nun | nber, City or Tow | | | 3 |
| e 6 may be ector, page must be | | 20g. METHOD OF DISPOSITION 1 X Buriel 2 Cremetton | | | 20 | b. PLACE | OF DISPO | SITION /A | lame of c | emetery cm | metory or | | | CATION — C | | |
| D 60 - | | 4 Donation 5 Other (Sp | | Will from State | - 0 | New | Ca | thed | lral | L Cer | nete | ery | Ba | ltimo | ore, | MD |
| death. Page tuneral dire I. examiner n | | 1 ABuriel 2 Cremetton 3 Removel from State 4 Donatton 5 Other (Specify) New Cathedral Cemetery Baltimore, MD 21. SIGNATURE OF FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE LICENSE MACRO FUNERAL SERVICE MACRO FUNERAL SERV | | | | | | | | | | | | | | |
| after death. y the funera moval. ical exami | - 6 | George E. MacNabb 301 Frederick Rd., Catonsville, MD | | | | | | | | | | | | | | |
| or within 24 completely filled in the completely filled in the company or reservent, the medianed | N | iMMEDIATE CAUSE (Final disease or condition resulting in death) | t failure. L | DUE TO | Sept OR AS | A CONSE | QUENCE (| Sha | ock | - on | P. | neu | mon | C . | | Approximata Interval Betwee Onset and Deat |
| th certificate be ending physician I Hygiene prior I or other trau | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | | |
| that the ed by the h and M any Inju | EDICAL | PART ii. Othar aignificant | conditions | s contributing to | daath i | but not i | resulting | in tha u | indarlyi | ng csuse | given in | Part i. | 24a. WAS AN PERFOR | MED? | CC | ERE AUTOPSY FINDINGS AILABLE PRIOR TO OMPLETION OF CAUSE DEATH? |
| law requires as been signe Dept. of Healt 23 shows | Σ | | | | | | | | | | | _ | | | 1 | YES 2 NO |
| V: The cate has State D | SICIAN: | 25. WAS CASE REFERRED TO N EXAMINER? | MEDICAL | HOSPITAL: | ngue | Tage 2 | | ОТНЕ | | PLACE OF | DEATH (C | heck only o | one) | | | |
| ICIAN: entific the S | HYS | 1 YES 2 NO | | 1 XInpatient 2 | | patient 3 | DOA 28b. TI | | _ | ome 5 - F | teeldence | | er (Specify) | N HIRW OCC | IDED | |
| NG PHYS fler this c eath with marked, | ВУ РЬ | 1 Natural 5 Per | nding estigation | (Month, L | Day, Year) | | - 16 | JURY | 1 [| YORK? YES 2 | □ NO | 200. 00 | SCHIBE HOW | NJOHY OCC | JREU | |
| 5 4 5 m | ETED | | uld not be ermined | 28e. PLACE (building | OF INJUR , etc. (Spe | | ome, farm, | ztreet, fa | ctory, aff | fice | | | CATION (Street y or Town, State) | | or Rural Rou | e Number, |
| The Hospital or Atten The Funeral Director: filed within 72 hours after Portant: It item 28 Is | COMPLE | Condon Only | | CIAN: To the best of a | | | | | | | | | | | | nd manner as stated. |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 I | BE C | 296. SIGNATURE AND TITLE OF | F CERTIFIER | 1 2 | | 1 | 1 | | | 29c. Life | CENSE NU | MBER | | 29d. DATE | SIGNED (M | onth, Day, Year) |
| ₽₽\$ | 2 | 30. NAME AND ADDRESS OF P | ERSON WH | O COMPLETED CAL | ISE OF D | EATH OTE | Tell | a Printi | | | | | | 1 | 114 | 170 |
| The last | | | | 1 a Kesle | | | Ü | ron | M | em | Ho. | SPO | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. | O THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. |
|---|--|
| | has been signed by the attending physician an |

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | STATE OF MARYLAND | | | HEALTH AND M | MENTAL HYGIEN | _ | 0 07200 |
|--|--|---|---------------|--|--|---------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | Vorring Dres | Mo. | ••• | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| KEVIN MAYO | Kevin Bru | ice may | yo | | 12 10 |) 1990 | 05:40 P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. | | F UNDER 1 YEA | | 7. DATE OF BIRTH | 8. B | HRTHPLACE (State or Foreign |
| 577 92 9035 | ¹√ M 2 □ F 3 1 | YRS. | DAY | B HOURS MIN. | (Month, Day, Year) 9 - 3 0 - 5 9 | | wash, DC |
| 9a. FACILITY NAME (If not institution, give s | treet and number) | 9 | b. CITY, TOV | N OR LOCATION OF DE | ATH | 9c. COUNTY | |
| THE JOHNS HOPK | INS HOSPITAL | | BALT | IMORE CITY | | BALTI | MORE CITY |
| RESIDENCE OF DECEDENT | | | | | | 1 | |
| M D | | | ltim | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER 1424 W. Mt. | Royal Ave A | pt lB | | 10f. ZIP CODE 2 1 2 1 7 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. | | 40 1100 | | | | |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | , NO | If yee | DECENDENT OF HISPAN , specify Cuben, Mexica YES 2 NO Specify | n, Puerto Ricen, etc.) | | RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECEDENT'S EDU (Specify only highest grade | CATION 18a. | . DECEDENT'S US | SUAL OCCUP | ATION | 18b. KIND OF BU | ISINESS/INDUST | RY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of wor life. Do NOT use i | | | | | |
| 12 yrs | 1 yr Re | cords | Admi | nistrato | r Insur | ance I | Business |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maide | Sumame) | |
| REID MAYO | | | | MARG | ARET BI | OK | |
| 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING A | DDRESS (Str | eet and Number or Rural F | Route Number, City or To | vn, State, Zip Cod | e) |
| Edward H. Cond | lon | 1424 V | v. Mt | . Royal | Ave., Ba | alto., | MD 21217 |
| 20e. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Rem | 20b. PL/ | ACE OF DISPOSIT | ION (Name o | cemetery, crematory or | 20c. L | OCATION — City | or Town, State |
| 4 Donetion 5 Other (Specify) | Met | tro Cre | emato | ry, Inc. | Ba: | Ltimor | e. MD |
| 21. SIGNATURE OF FUNERAL SERVICE THE | | | 22. NAM | E AND ADDRESS OF FA | CILITY | | |
| Seog C. | 1NI-1-1 | | Cre | emation S | ociety o | of Mar | yland |
| George E. M. 23. PART I. Enter the disesses, or | | | | | | | MD 21228 |
| IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | s. Respirat DUE TO/OR AS A CON B. Kaposi | ns Found of 5 | ne | ne 2° f | neimm | ia | Interval Between Onset and Desth 4 days 6 MB |
| Sequentielly list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evante resulting in deeth) LAST | DUE TO (OR AS A CONDUE TO (OR AS | rseovence of): | in Ge | | | | 3 yrs |
| PART II. Other significent condition | _ | ot resulting in | the undsri | ying cause given in | | N AUTOPSY PRMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| _Toxoplas m | 65/5 | | | | 1 🗆 YES | \ \ | COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | 20 | B. PLACE OF DEATH (Ch | eck only one) | | |
| 1 TES 2 NO | HOSPITAL: 1 Vinpatient 2 ER/Outpatien | | THER: | Home 5 - Reeldence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME | OF 28c | INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCURE | ED |
| 2 Accident 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — A building, etc. (Specify) | At home, ferm, atr | eet, fectory, | office | 281. LOCATION (Street City or Town, State | and Number or R | lural Route Number, |
| anal | ICIAN: To the best of my knowledge | | | | | | use(e) end menner ee stated. |
| 200. SIGNATURE AND PETER OF CERTURE | ~ MD | | | 29c. LICENSE NUI | | | GNED (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON WE | | | | D MD | | | , , , , |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATUR | | DAG | 10 1912 | 420) | | |
| DEC 1 4 1990 4 | which Tavidson Banda | 00 | | | | | |



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31. DATE FILED (Month, Day, Year)

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physician and completely filler me prior to burial, cremation,

| DIVISION OF VITAL | DIVISION OF VITAL RECORDS, P.O. BOX 1314 | BOX 1314 |
|---|---|----------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the target of executed | SICIAN: The law requires that me the | art cate be executed |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed in the amount and col | certificate has been signed in the areand | hysician and co |
| be filed within 72 hours after death with the State D | the State Dept. of Health and Montal | perior to burial. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic e | 1, or Item 23 shows any injury, or | other traumatic e |

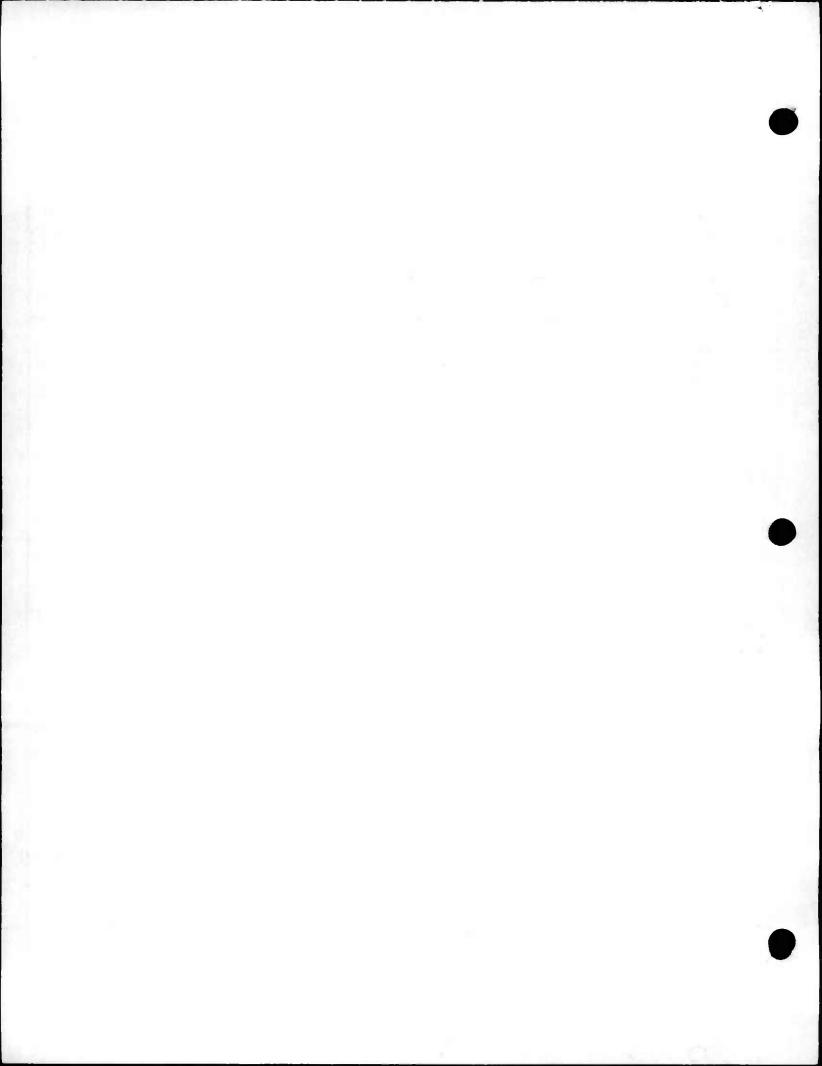
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH DECEMBER 12, LOUISE McMANUS 1990 6:45 P. 4. SOCIAL SECURITY NUMBER 5. SEX 7. OATE OF BIRTH (Morth, Day, Year) SEPT. 6, 6. AGE (in vrs. last hirthday) IF UNDER 1 YEAR | IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign 025-20-2166 1 M 2 X F DAYS HOURS MIN YRS. 1901 CANADA 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR FREDERICK VILLA NURSING HOME CATONSVILLE BALTIMORE RESIDENCE OF DECEDENT 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE CATONSVILLE 1 YES 2 X NO FUNERAL 10e. STREET AND NUMBER 10f ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1617 PARK GROVE AVENUE 21228 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ZINO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or NoIt yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 X NO Specify: 14. RACE — American Indien, Black, White, etc. 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES BY 3X Widowed 4 Divorced WHITE COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY during most of working (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) 8 HOUSEWIFE OWN HOME 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) HIRAM LANGILL BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 DOROTHY L. SMITH 1617 PARK GROVE AVENUE, CATONSVILLE, MD. 21228 (DAUGHTER) 20s. METHOD OF DISPOSITION
1. Burlel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cometery, crematory or 20c. LOCATION - City or Town, State LORRAINE PARK CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MARYLAND 21. SIGNATURE OF EUNERAL'SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY LEORY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory erreat, shock, or hear failure. List only pris cause on sech line. Approximete IMMEDIATE CAUSE (Final Onset and Death disease or condition resulting in death) CONSEQUENCE OF CERTIFICATION -Sequentially list conditions. if any, leading to immediate ENCE OF cause. Enter UNDERLYING CAUSE (Diseese or injury 1 DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY 1 - YES 2 NO 1 | YES 2 | NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 | YES 2 STHER: 1 | Inpatient 2 | ER/Outpetient 3 | DOA ng Home 5 - Residence 6 - Other (Specify) T. MANNER OF DEATH 26a. DATE OF INJURY (Month, Day, Year) 26b. TIME (28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Metural 2 Accident ВҰ 1 YES 2 NO 26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 6 Could not be 261. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide COMPLET THEYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(e) end manner as stated. EDICAL EXAMINER on and/or investigation, in my opinion, death occured at the time, date end place, end due to the cause(s) end manner as stated MIGNATURE AND TITLE OF CENTIFIES BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Your) so cun 2 2

516 N. ROLLING ROAD, SUITE 205, BALTIMORE,

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32 REGISTRAR'S MICHATURE

ALBUERNE M.D.



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| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAN | ND / DEPARTM | | | MENTAL HYGIENE REG. NO. | 90 | 34257 |
|-----------------|--|--|--|---------------------|---------------------|--|-------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | Y IO YEAR | 3. TIME OF DEATH |
| | Geraldine + | Morris | | 7.00 | | 12 | 14 90 | 1105 PM H |
| į | 218-24-8945 1 M 2 XF 65 YRS. MONTHS DAYS HOURS MIN. (MONTH), Dey, Yeer) Country) VIVGI | | | | | | | |
| OR | 90. FACILITY NAME (If not institution, give street end number) 90. CITY, TOWN OR LOCATION OF DEATH 90. COUNTY OF GEATH 90. COUNTY OF GEATH 90. COUNTY OF GEATH | | | | | | | |
| | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | 10c, CITY, TO | OWN OR LOCATI | ON | | | 10d. INSIDE CITY |
| DIRECTOR | Md - | | | utim | | | | LIMITS? 1 XYES 2 NO |
| AL | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZEN OF | |
| FUNERAL | 701 New Pitts | | | | 21222 | | US | |
| BY FU | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | 2. WAS DECEDENT EVER IN U FORCES? 1 — YES IF YES, GIVE WAR OR DATI | PANO. | If yes, spe | | IIC ORIGIN? (Specify Yee n, Puerto Ricen, atc.) :: | or No 14. RAC Blac Spec | E — American Indien, k, White, atc. |
| G | 15. DECEDENT'S EDUCAT (Specify only highest grade con | ION 1 | 6a. DECEDENT'S USU (Give kind of work | IAL OCCUPATIO | N t of working | 16b. KIND OF BUS | SINESS/INDUSTRY | |
| COMPLET | | College (1-4 or 5+) | life. Do NOT use rei | sewife | | | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | | |
| BE | Colnel Finney | | | | | a Hall G | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Gilda Weaver | | | | | Poute Number, City or Town . Maryla | |) 2 |
| | 20. METHOD OF DISPOSITION | 20b. F | LACE OF DISPOSITIO | ON (Name of cerr | etery, crematory or | | CATION — City or T | |
| | 1 Suriel 2 Cremation 3 Remova 4 Donetion 5 Other (Specify) | I from State | menter. Zi | on Cei | netery | Po | whattar | ı,Va. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICEN | | | 22. NAME AN | o Accress of FA | S F7H 17 | 21-27 N | I.Monroe |
| ╝ | Noutha. | Lector | #281 | | | St | .Balto. | ,MD.21217 |
| | 23. PART I. Entar tha diseases, or con shock, or heart failure. Lia IMMEDIATE CAUSE (Final | | | antar tha mod | de of dying, auc | h aa cardlac or reapl | ratory arreat, | Approximata Interval Batween Onset and Daath |
| | disessa or condition resulting in death) s | DUE TO (PR AS A P | monto | | | | 0 | 7day1 |
| z | 6 6 | Metasti | atre | 54-Ln | myul Ci | ell Canca | Claphy | () year |
| RTIFICATION | Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING | OUE TO (OR AS A C | CONSEQUENCE OF): | 1 | 1.00 | ell Carca | | 100000 |
| FIC | CAUSE (Disease or injury that initiated events | OUE TO (OR AS A C | CONSEQUENCE OF): | ung | a se | acc | | (year) |
| ERT | reaulting in death) LAST | | | | | | | |
| L CE | PART II. Other significant conditions of | contributing to death but | t not reaulting in t | ha undariying | cause given in | | | b. WERE AUTOPSY FINDINGS |
| ICAL | | | _ | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDI | | | | | | _ | | 1 NES 2 NO |
| Ž | | | | | | | | |
| 200 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | | THER: | ACE OF DEATH (Ch | N | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF INJURY | 28b. TIME O | F 28c. INJ | JRY AT | 6 ☐ Other (Specify) 28d. DEŞCRIBE HOW II | NJURY OCCURED | |
| BY P | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | | RK? 'ES 2 NO | | | |
| COMPLETED E | 3 Suicide 8 Could not be 4 Hornicide determined | 28e. PLACE OF INJURY – building, etc. (Specif) | At home, farm, atree | nt, factory, office | | 261. LOCATION (Street e City or Town, State) | | Route Number, |
| | TOTOCK OTTY | AN: To the best of my knowled | dge, death occurred a | t the time, date | end place, end due | to the cause(e) end man | nner as stated. | |
| <u>Ş</u> | one) 2 MEOICAL EXAMINER: | On the basis of examination | end/or investigation, i | n my opinion, d | eath occured at the | time, date and piece, en | nd due to the ceuse | (e) end manner ee stated. |
| BEO | 266. SIGNATURE AND TIPLE OF CERTIFIER | | | | 29c. LICENSE NUI | | | D (Month, Day, Yeer) |
| ဥ | 30, NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Time Del | int) | D29565 | | 12/1 | .3/90 |
| | Philip C. Buescher. | M.D. 201 | East Univ | | Parkway | Baltimor | e, Marvl | and 21218 |
| | 31. OATE FILED (Month, Day, Year) DFC 14 1990 | 32 REGISTRAR'S SIGNA | Mande 11 | | | | | 21210 |
| | DEC 1 4 1990 | gretie Deutidson | -Market | | | | | |

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| Jours after death. Page 6 may be retained by the hospital or attending physician. | tetely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | nt, the medical examiner must be notified at once. |
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BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 23146, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifican to the manual properties that the certificate has been signed by the attending procedure to fled within 72 hours after death with the State Dept. of Health and Mental Hyglenn ever in unity central

IMPORTANT: If Item 28 Is marked, or Item 23 shows any Injury, or other train

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH BEG NO.

| | REGISTRAR | | OL. | _ | IONIE O | DEATH | REG. NO | | | |
|------------------------------------|--|--|--|--|--|--|---|--|--|---|
| - 8 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH MONTH D | NY. | YEAR 3. | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 1 | 6. AGE (In yrs. las | ma | ^ | | 12-1 | 1 - | 20 | 21.02PM |
| - 18 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | | ACE (State or Foreign |
| - 8 | 167-18-6489D | 1 □ M 2 😿 | 8-7 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 3/24/03 | - 1 | Country) | ermany |
| | 9a. FACILITY NAME (If not institution, give s | treet and number) | 0 | | 9b. CITY. TOWN | OR LOCATION OF DE | | ac com | TTY OF DEAT | |
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| DIRECTOR | Baltimore Co. Gen | | Kar | dallstown | 1 | B | altim | ore | | |
| E C | 10a. STATE 10b. COUNT | , | | 10c. CITY | Y, TOWN OR LOC | ATION | | | 10 | d. INSIDE CITY |
| E | Maryland Car | roll | | 1 | C1 | 11. | | | l. | LIMITS? |
| 5 | 10e. STREET AND NUMBER | 1011 | | 1 | Sykesvi | TTE | | 10- OIT | | T COUNTRY? |
| FUNERAL | | | | | | | | - | | |
| | 7309 Second Av | | | | | 21784 | | | ited : | States |
| 글 | 11. MARITAL STATUS | | T EVER IN U.S. AR | | 13. WAS D | ECENDENT OF HISPAN specify Cuban, Mexica | IIC ORIGIN? (Specify Years, Puerto Rican, etc.) | or No- | 14. RACE Black, W | American Indian, /hite, etc. |
| BY | 1 Never Merried 2 Merried *XX Widowed 4 Divorced | IF YES, GIVE V | | | 1 🗆 Y | ES 2 No. Specifi | /: | | Specify: | |
| | | l | | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DE | CEDENT'S ive kind of w | USUAL OCCUPA vork done during i se retired.) | TION most of working | 18b. KIND OF BU | SINESS/IND | USTRY | |
| Щ | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | | 10 |
| ē | 8th grade | | | Hous | ewife | | | | | |
| Ö | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | Sumame) | | |
| | Emil Lorenz | | | | | Marie | Raabe | | | |
| BE | 19a, INFORMANT'S NAME (Type/Print) | | 191 | . MAILING | ADDRESS (Stree | t and Number or Rural | Route Number, City or Tow | n, State, Zip | Code) | |
| 5 | Ms. Sylvia Fetter | | 1 | | | | Sykesvil: | | | 784 |
| | 200. METHOD OF DISPOSITION | | 20h PLACE | | | cemetery, crematory or | | | City or Town, | |
| | 1 Burlet 2 S Cremetion 3 Rem | oval from State | other pla | Car | rell Cr | emation of | Service Ha | mnet | and 1 | VID. |
| 1 | 4 Donation 5 Other (Specify) | mode. | | Car | | AND ADDRESS OF FA | | ımpst | eau, i | ш |
| | 21, SIGNAL DE OF FUNERAL SERVICE LI | The state of | | / | | | Funeral He | nme | | |
| _ \ | AMGI P | 110 | 101 | | | | Road Rane | | town. | MD 21133 |
| | 23. PART Enter the diseases, pr | complications the | it caused the da | ath. Do n | | | | | | Approximata |
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| | disease or condition | a. Col | // | | 5000 | = /4 | | | | |
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| NC | disease or condition reaulting in death) | | OR AS A CONSE | DUENCE OF | • | | retion. | | | |
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| | | the death certificate be executed within 24-mours after death. Page | and control of the co |
| | DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death detrificate be executed within 2 modus after death. Page 6 may be retained by the hospital or attending physician. | The state of the s |

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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or remoral. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF N | IARYLAND / Ce | | | OF HEALTH | | MENTAL | HYGIENE REG. NO. | 9 | 0 3425 |
|---|---|--|--|---|--|--|---------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) NORM | A | | | PAR | RHAM | | 2. DATE OF MONTH | OF DEATH DAY | 2, 19 | 3. TIME OF DEATN 90 2:32 A |
| | 4. SOCIAL SECURITY NUMBER 219-32-6437 | 5. SEX | | | | F UNDER 1 YEAR F UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | | DE BIRTH Day, Year) | BIRTNPLACE (State or Foreign Country) | |
| | 9e. FACILITY NAME (If not Institution, give str | | 59 | | 9b. CITY, T | TOWN OR LOCAT | ION OF DE | | 77.3 | OF DEATH | |
| TOR | THE JOHNS HOPKIN | TAL BALTIMORE | | | | | | BALTIMORE CITY | | | |
| DIRECTOR | md. 10b. COUNTY | | | 10c. CITY, | TOWH OR | LOCATION | | | | - | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | 100. STREET AND NUMBER 1605 BRAD | Card | C-+- | | , | 10f. ZIP CO | DE 7 12 | 16 | | | OF WHAT COUNTRY? |
| FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married | | | MED | 11 1 | AS DECENDENT yea, specify Cut | en, Mexice | n, Puerto R | ? (Specify Yee licen, atc.) | | . RACE — American Indian, Black, White, atc. |
| р ву | 3 Widowed 4 Divorced 15. DECEDENT'S EDUC | 22.34234 | 16a, DEC | CEDENT'S US | SUAL OCC | YES 2 1 NO | | | KIND OF BUS | INESS/INDUS | Vegno |
| COMPLETED | (Specify only might grade | College (1-4 or 5 | (Gh | ve kind of wor Do NOT use | retired.) | ring most of world | | | 33,100 | | |
| COM | 17. FATHER'S NAME (First, Middle, Last) | | | 43/10 | 3 | | | ME (First, N | fiddle, Meiden S | | |
| BE (| 190. INFORMANT'S NAME (Type/Print) | Ange | 196 | . MAILING A | ADDRESS (| (Street and Numb | er or Rural | Route Numb | er, City or Town | | 250H |
| 5 | RITH Round | tree | | 201 | 9 1 | F. L. | 9nV | Ala | 57 | | |
| | 20a. METNOD OF DISPOSITION 1 Souriel 2 Cremation 3 Remo 4 Oonation 5 Other (Specify) | | 20b. PLACE Cother lie | OF DISPOSIT | TION (Nam | e of cemetery, cr | ematory or | | 20c. LOC | CATION — CITY | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ensee Y AEN | al 140 | ne | 22. N/ | AME AND ADDR | ess of fa | CILITY | calin | 1 8 | |
| | 23. PART I. Enter the diseases, or c shock, or heart fellure. I | | | 1-1 | | | | 7 | | | |
| shock, or heert fellure. Liet only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition | | | | | | ha mode of d | ying, suc | th se cerd | lec or reapli | retory arreed | Interval Between |
| | | Liet only one cau | cadcul | in | ot antar th | the mode of d | ying, suc | th ae cerd | llec or reapli | retory arreef | |
| N | disease or condition resulting in deeth) | Liet only one cau | iee on each line. | DUENCE OF): | asc ona | tion | ying, suc | 1. | CG YL | retory arreef | Interval Between |
| CATION | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUÉ TO | cadcul | DUENCE OF): | lasc | tion | ying, suc | 1. | | retory arreet | Interval Between |
| ERTIFICATION | disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate | B. MUD DUE TO DUE TO | cadcal (OR AS A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATION OF A CONSECULATI | DUENCE OF): | ona | tion | ying, suc | 1. | | retory arreef | Interval Between |
| AL CERTIFICATION | Sequentially liet conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente | B. MUD DUE TO | (OR AS A CONSECTION AS A CONSE | DUENCE OF): | ona | tion my a. | Fey | dis | 240. WAS AN. | AUTOPSY | Interval Between Onset and Death 2 days 2 years. |
| I I | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST | B. MUD DUE TO | (OR AS A CONSECTION AS A CONSE | DUENCE OF): | ona | tion my a. | Fey | dis | cox | AUTOPSY MED? | Interval Between Onset and Death 2 days 2 years. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST | B. MUD DUE TO | (OR AS A CONSECTION AS A CONSE | DUENCE OF): | ona | tion my a. | Fey | dis | 24a, WAS AN. PERFOR | AUTOPSY MED? | Interval Between Onset and Death 2 days 2 years. |
| MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST PART II. Other significant condition AND AND AND AND AND AND AND AND AND AND | DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO | (OR AS A CONSECTION OF A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF AS A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSECTION OF A CONSEC | DUENCE OF): | oraci: | tion darlying couse 28. PLACE OF | given in | Part I. | 24a. WAS AN. PERFOR 1 UYES 2 | AUTOPSY MED? | Interval Between Onset and Death 2 days 2 years. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST PART II. Other significant condition PART II. Other significant condition PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO | (OR AS A CONSECTION OF AS A CONS | DUENCE OF): | OTHER: | larlying couse 28. PLACE OF: ing Nome 5 □ 28c. INJURY | given in | Part I. | 24a. WAS AN. PERFOR 1 UYES 2 | AUTOPSY MED? | Interval Between Onset and Death 2 days 2 years. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 8 Could not be | DUE TO DU | (OR AS A CONSECTION OF AS A CONS | DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): | OTHER: | 28. PLACE OF: ing Nome 5 = 28c. INJURY AT WORK? 1 YES 2 | given in | Part I. Part I. Pack only on 6 Other 28d. DES | 24a. WAS AN. PERFOR 1 YES 2 | AUTOPSY MED? NO NO | Interval Between Onset and Death 2 days 2 years. 24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST PART II. Other significant condition PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 29 Accident Could not be determined | B. DUE TO | (OR AS A CONSECTION OF INJURY — At horetc. (Specify) | DUENCE OF): UENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DOA 4 28b. TIME INJUI me, farm, str | OTHER: OTHER: Grant Marsin of Street, fector d at the tim | 28. PLACE OF: ing Nome of : in | DEATH (C) Recidence | Part I. Beck only one Bed Other 28d. DES 28f. LOC. City. | 24a. WAS AN PERFOR 1 YES 2 ATION (Street a or Town, State) | AUTOPSY MED? NO NJURY OCCUP Ind Number or | Interval Between Onset and Death 2 Jacqs 2 Jacqs 2 Jacqs 2 Jacqs 2 Jacqs 1 Jacqs 2 Jac |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted evente resulting in daeth) LAST PART II. Other significant condition PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 29 Accident Could not be determined | DUE TO DU | (OR AS A CONSECTION OF INJURY — At horetc. (Specify) | DUENCE OF): UENCE OF): DUENCE OF): DUENCE OF): DUENCE OF): DOA 4 28b. TIME INJUI me, farm, str | OTHER: OTHER: Grant Marsin of Street, fector d at the tim | 28. PLACE OF: ing Nome 5 = 28c. INJURY AT WORK? 1 YES 2 ry, office | DEATH (C) Recidence | Part I. Peck only on 6 Other 28f. LOC. City. | 24a. WAS AN PERFOR 1 YES 2 ATION (Street a or Town, State) | AUTOPSY MED? NO NJURY OCCUP Ind Number or Iner ee stated. d due to the co | Interval Between Onset and Death 2 Jacqs 2 Jacqs 2 Jacqs 2 Jacqs 2 Jacqs 2 Jacqs 1 Jacqs 2 Jac |

29a. CERTIFIER (Check only one) 2 ___ MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) end menner as stated. 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 600 N WE STATE STREET STREET 31. DATE FILED (Mogth,

STREET, ROBERT P.

YEAR

90

9c. COUNTY OF DEATH

BALTIMORE

U.S.A.

10g, CITIZEN OF WHAT COUNTRY?

WHTTE

21157

MD

Approximete

24b. WERE AUTOPSY FINDINGS

9 0

DF DEATH? 1 YES 2 NO

NO

29d, DATE SIGNED /Month

21208

365, BALTIMORE, MD.

AVAILABLE PRIOR TO COMPLETION OF CAUSE

interval Between

Onset and Deeth

86

2. DATE OF OEATH MONTH 12 1

7. DATE OF BIRTH

12/19/04

3

STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

GLADYS

9e. FACILITY NAME (If not institution, give street and number)

4 SOCIAL SECURITY NUMBER

216-42-9368

J. PFEIFFER

5. SEX

1 M 2 TF

1 -

| BOX 13146, |
|------------|
| P.O. |
| RECORDS, |
| VITAL |
| N O N |
| DIVISION |

BE

2

KENNETH

be detached for use as the burial-transit permit. Pages 1, 2, 3 should DIRECTOR ERIDIAN NURSING HOME RANDALLSTOWN RESIDENCE OF DECEDENT 10e. STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION IARYLAND WESTMINSTER CARROLL FUNERAL 10a STREET AND NUMBER 10f. ZIP CODE 647 N. GORSUCH ROAD 21157 nours after death. Page 6 may be retained by the hospital or attending physician. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-If yea, specify Cuben, Mexicen, Puerto Rican, atc.) 1 ☐ YES 2 ∯ NO Specify: 1 Never Merried 2 Merrie 3 Wildowed 4 Divorced BY COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 185 KIND OF BUSINESS/INDUSTRY (Specify only high Elementary/Secondary (0-12) College (1-4 or 5 +) OWN HOME HOUSEWIFE once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) THOMAS notified at JOHNSON MARGARETA CASHMYER BE companied filled in by the funeral director, page 5 should an exemption, or removal. 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 (DAUGHTER) EGGY DOVELL 647 N. GORSUCH ROAD WESTMINSTER, MD must be 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or METHOD OF DISPOSITION

Burlal 2

Cremation 3

Removal from State 20c. LOCATION - City or Town, State LOUDON PARK CEMETERY 4 Donation 5 Other (Specify) BALTIMORE. examiner 21. SIGNATURE OF FUNERAL SERVICE DICENSES 22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOME usselle, 1630 EDMONDSON AVE CATONSVILLE medical 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart fallure. List only one ceuse on each line. 0 IMMEDIATE CAUSE (Final the disease or condition within resulting in death) event, 05 CERTIFICATION Sequentially list conditions. OUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events After this certificate has been signed by the amount death with the State Dept. of Health and Merzel Hyper resulting in death) LAST b n un. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a, WAS AN AUTOPSY requires that the shows any 1 [] YES 2 PHYSICIAN: TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If item 28 is marked, or item 23 s. 28. PLACE OF DEATH (Check only one) 25. WAS CASE REFERRED TO MEDICAL HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Residence 8 - Other (Specify) 26e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TWE OF 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO ВУ Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 29a. CERTIFIER 1 / CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the tima, date end place, end due to the cause(e) end manner as stated. investigation, in my opinion, death occ red at the time, date and piece, and due to the cause(e) end manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27 (Type, Print)

ZONIES

ALISTERSTON

1777 REISTERSTOWN ROAD,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

IF UNDER 1 YEAR IF UNDER 24 HRS.

9b, CITY, TOWN OR LOCATION OF DEATH

DAYS

8. AGE (In yrs. last birthday)

YRS.

90 34260

8. BIRTHPLACE (State or Foreign

MARYLAND

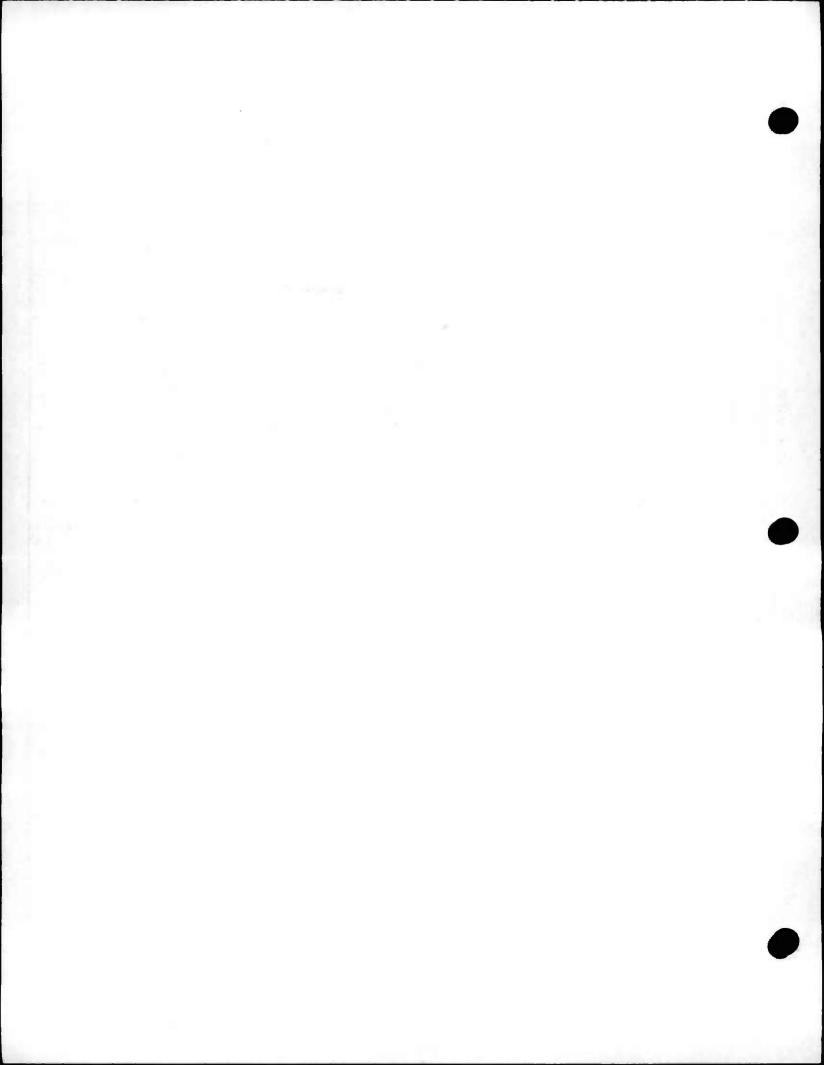
3. TIME OF DEATH

10d. INSIDE CITY

14. RACE — American Indian, Black, White, etc.

1 TYES 2 NO

4:30 A



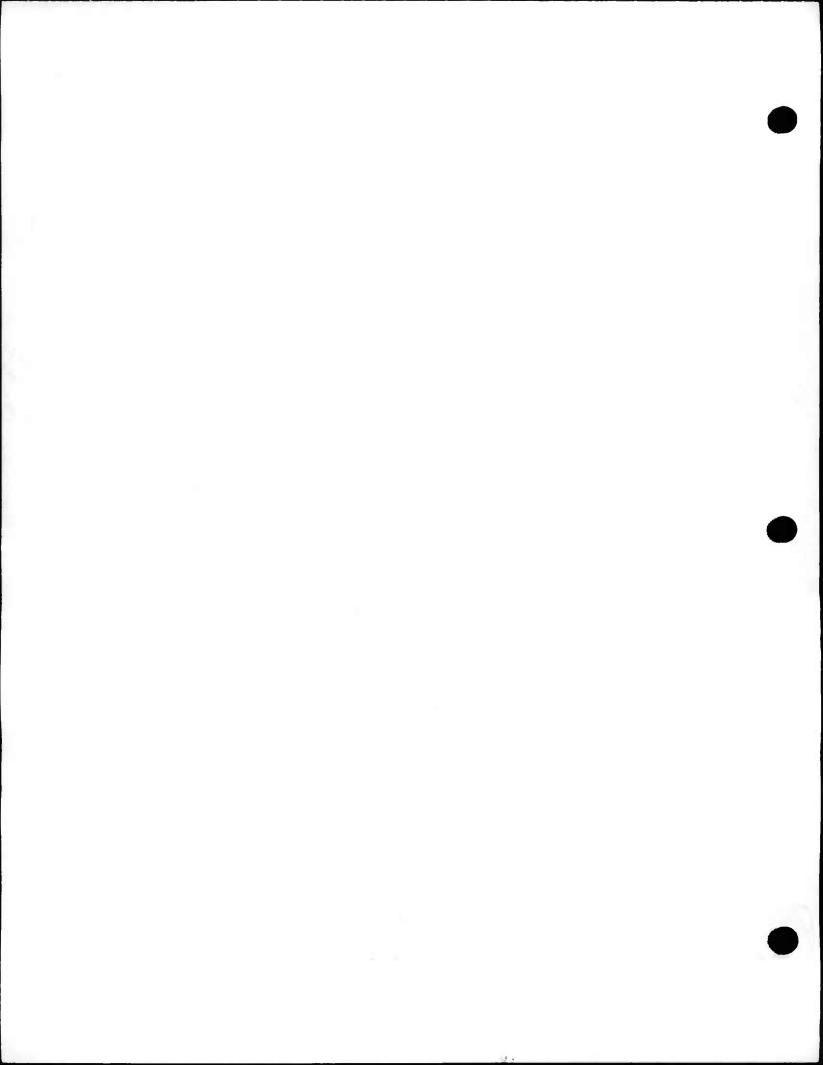
| BALTIMORE, MARYLAND 21203-3146 | n 24 mours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | the medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filed within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| 1 - | FOR STATE REGISTRAR |
|------|---------------------------|
| 1. D | ECEDENT'S NAM |
| | Herman |
| 4.0 | OCIAL OFCURITO |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CE | :KI IF | CALE | OF DEATH | - | REG. NO. | | | | |
|---------------|--|-------------------------------------|---------------------------|--------------|-----------------|-------------------------------|---------------|--|---------------|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | - | | | | 2. | DATE OF DEATH | | 3 | . TIME OF DEATH | |
| | House H DOUD | MAN Sr | | | | | _ | cember 1 | 3 199 | YEAR | 12:38 P M | |
| | Herman W ROHR | | GE (In yrs. lest | hirthday) | IF UNDER 1 Y | EAR IF UNDER 24 | | DATE OF BIRTH | | | ACE (State or Foreign | |
| | 213 10 0921 | 1 😡 M 2 🗆 F | | YRS. | | | MIN (| (Month, Day, Year) | | Country) | | |
| | | A | 82 | 1110. | | | | 1/29/08 | | | imore | |
| | 9e. FACILITY NAME (If not institution, give s | treet end number) | | | 9b. CITY, TO | WN OR LOCATION | OF DEATH | | 9c. COUNT | Y OF DEA | TH | |
| ဗျ | Franklin Square Hospital | | | | | sville 2 | 21237 | | Balt | Baltimore County | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| <u> </u> | 10e. STATE 10b. COUNTY | Y | | 10c. CIT | Y, TOWN OR L | OCATION | | | | 1/ | Od. INSIDE CITY LIMITS? | |
| <u> </u> | Maryland Balti | more Count | z v | Mi | ddle 1 | River | | | | _ 1 | YES 2 X NO | |
| ا پ | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | 10g. CITIZE | N OF WN | AT COUNTRY? | |
| FUNERAL | 20 Stablizer Dri | VO. | | | | 212 | 20 | | | | | |
| ۳ I | 11. MARITAL STATUS | 12. WAS DECEDENT EVI | | 455 | | 1 | | | | ı.s.a | | |
| 립 | 1 Never Married 2 Merried | FORCES? 1 Y | ES 2 N | O | 13. YMA | s DECEMBENT OF | Mexican, Pu | PRIGIN? (Specify Yee werto Rican, etc.) | or No- 1 | Black, 1 | - Americen indien, While, etc. | |
| E A | 3 🔀 Widowed 4 🗌 Divorced | IF YES, GIVE WAR O | R DATES | | 1 🗆 | YES 2 THE NO | Specify: | | | Specify: | 1.71L - 2 - L - L | |
| | X | 1 | | | | | | | | | White | |
| = | 15. DECEDENT'S EDU (Specify only highest grade | | (Gh | ve kind of v | USUAL OCCU | IPATION ng most of working | | 16b. KIND OF BUS | INESS/INDU | STRY | | |
| <u>ا</u> ب | Elementery/Secondery (0-12) | College (1-4 or 5+) | | Do NOT us | sa retired.) | | | 1 | | | | |
| COMPLETED | 6 | | Dr | iver | | | | Trans | it Co | mpan | у | |
| śΙ | 17. FATNER'S NAME (First, Middle, Lest) | | _ | | | 18. MOTHE | R'S NAME (| (First, Middle, Malden | | | | |
| | Ernest Rohrman | | | | | F1 | izabo | eth Merce | r | | | |
| 8 | 19e. INFORMANT'S NAME (Type/Print) | | 1.40 | | ADDRESS (C | | | Number, City or Town | _ | D= -(-) | | |
| 2 | | | - 1 | | | | | • | | | | |
| - | Anita Jane Koontz | | | | | | | cimore Ma | | | | |
| | 20e. METNOD OF DISPOSITION 1 1 Buriel 2 Cremellon 3 Rem | oval from State | 20b. PLACE (| OF DISPOS | SITION (Name | of cemetery, cremat | tory or | 20c. LO | CATION — CI | ty or Town | n, State | |
| | 4 Donellon 5 D Other (Specify) | TOWN HOW STATE | Holly | Ĥil] | L Memo | rial Gar | rdens | Ba1t | timore | - Cor | inty, Md | |
| | 21. SIGNATURE OF FUNERAL SEPTICE LIC | | | | | ME AND ADDRESS | | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |
| | 1/2 | 0 - 1 | | | Bruz | zdzinski | Fune | eral Home | P.A. | | | |
| | Mans Dry | trans | 0 | | | | | | | o Mo | ryland 212 | |
| | 23. PART V Enter the diseases, or | complications that car | sed tha de | ath. Do r | not antar th | a moda of dyln | g, such as | s cardiac or respi | retory srre | st, | Approximate | |
| | shock, or haart fallure. | List only one cause of | n aach lina | • | | | | | | | Interval Batwean Onset and Death | |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | Oliset and Death | |
| | resulting in death) | a. Pneumo | nia | | | | | | | | | |
| - 1 | | DUE TO (OR | AS A CONSEC | DUENCE O | F): | | | | | | | |
| z I | vaccore and anticonsumous | L Chroni | c Obst | ruct | ive P | ulmonary | v Dis | ease | | | | |
| 읟 | Sequantially list conditions, If any, lasding to immediate | DUE TO (OR | AS A CONSEC | DUENCE O | F): | | , | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING | e Connes | tive H | loant | Fail | uro | | | | | | |
| Ĕ | CAUSE (Disease or Injury that Initiated events | Conges | AS A CONSEC | UENCE O | F): | uie | | | | | | |
| = | resulting in death) LAST | | | | | | | | | | | |
| 8 | | 0 | | | | | | | | | + | |
| | PART II. Other significant condition | ns contributing to das | th but not r | esulting | In the unda | riying cause gl | van in Par | | | | VERE AUTOPSY FINDINGS | |
| DICAL | | | | | | | | PERFOR | | | WAILABLE PRIDE TO COMPLETION OF CAUSE | |
| | | | | | | | | 1 YES 2 | XNO | | OF DEATH? | |
| Σ | | | | | | | | - | | 1 | YES 2 NO | |
| ż | | | | | | | | | | | | |
| <u> </u> | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 26. PLACE OF DE | ATN (Check o | only one) | | | | |
| PHYSICIAN: | 1 YES 2 NO | HOSPITAL: 1 √ Inpatient 2 □ ER | Outpatient 3 | □ DOA | OTHER: | g Home 5 🗆 Reel | Idence 8 🗆 | Other (Specify) | | | | |
| È∣ | 27. MANNER OF DEATH | 28e. DATE OF INJU | IRY | 28b. TIM | E OF 28 | c. INJURY AT | | d. DESCRIBE NOW II | NJURY OCCI | JRED | | |
| | 1 Natural 5 Pending | (Month, Day, Ye | | IN. | JURY | WORK? | | | | | | |
| B | 2 Accident Investigation | | O APPRA | | | 1 YES 2 | | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF IN. building, etc. | IURY — At ho (Specify) | me, ferm, | street, factory | , office | 28 | If. LOCATION (Street a City or Town, Stete) | and Number o | r Rural Ro | ute Number, | |
| | 4 Nomicide determined | | | | | | | | | | | |
| ן ב | 29e. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my I | mowiedge, de | ath occur | ad at the time | date and place | and due to 1 | the course(s) and mar | mer ee etele | d | | |
| Σ | Torroom only | ER: On the basis of examin | | | | | | | | | and manner or state of | |
| COMPLETE | MEDICAL EXAMIN | En. On the basis of exami | | n westigstk | un, in my opir | non, demit occure | u at the time | e, date end place, en | u due to the | ceuse(e) (| end menner ee stated. | |
| Ш | 29b, SIGNATURE AND TITLE OF CERTIFIE | 1/ 1/4 | 7 | | | 29c. LICEN | ISE NUMBER | R, | 29d. DATE | SIGNED | Month, Day, Year) | |
| ∞ | March | 9- | | | | IN C | 100 | 65 | > / | 21, | 3/900 | |
| 9 | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE O | F DEATH (ITF | M 27) (7/04 | , Print) | 171 | | | | | | |
| | | | | | | | | | | | • | |
| | Marc Westle 900 | N Franklin | Squar | e Dr | rive R | altimore | e, Mar | ryland 21 | 237 | | | |
| | 31. DATE FILED (Month, Day, Year) | 32, REGISTRAR'S | | | | | | 3 | | | | |
| | 4 4 4000 | F 4 1 4 4 | 70 . | -00 | | | | | | | | |





1 - FOR STATE REGISTRAR

| BALTIMORE, MARYLAND 21203-3146 | 1.24 nours after death. Page 6 may be retained by the hospital or attending physician. |
|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAM: The law requires that the death certificate be executed within 25-mours after death. Page 6 may be retained by the hospital or attending physician |

| | | 1. DECEDENT'S NAME (First, Middle, Last) Walter | C. Robertson | | 2. DATE OF DEATH MONTH DAY | YEAR SO 1093 PM | |
|--|---------------|--|--|---|--|--|--|
| D | | 4. SOCIAL SECURITY NUMBER 5. SEX 8. | AGE (In yrs. last birthday) IF UNDER 1 1 YRS. MONTHS E | EAR IF UNDER 24 HRS. AYS HOURS MIN. | | e. BIRTHPLACE (State or Foreign Cauntry) Virginia | |
| , 2, 3 should | TOR | 98. FACILITY NAME (If not institution, give street and number) FRANCIS SCOTT KEY W RESIDENCE OF DECEDENT | ed (tr. Be | altimost | £ | ITY OF PUATY | |
| nit. Pages 1, | DIRECTOR | Maryland Baltimos | 10c. CITY, TOWN OR Sparro | location DWS Point | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| transit pem | FUNERAL | 10e. STREET AND NUMBER 9 05 A VENUE D SLASS 11. MARITAL STATUS 12. WAS DECEDENT E | rows loint | 101. ZIP CODE | i U.A. | | |
| as the burial-transit permit. Pages | BY | 1 Never Married 2 Married FORCES? 1 3. Widowed 4 Divorced IF YES, GIVE WAR | YES 2 NO II y | ea, specify Cuban, Maxican, YESPE NO Specify: | | 14. RACE — American Indian, Black, White, atc. Specify: White | |
| for use | LETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) | 16s. DECEDENT'S USUAL OCC (Give kind of work done dur life. Do NOT use retired.) | ing most of working | Steel Co. | | |
| be detache | E COMPL | 17. FATHER'S NAME (First, Middle, Last) John L. Robertson | | 18. MOTHER'S NAM | ME (First, Middle, Malden Sumame) | | |
| ge 5 should e notitied | TO BI | 19a. INFORMANT'S NAME (Type/Print) Terri S. Phillips | 3625 Dahl: | Street and Number or Rural Relation | oute Number, City or Town, State, Zip Palto., Md. 212 | Code) 20 | |
| firector, page | | 20g. METHOO OF DISPOSITION 1A0 Burlel 2 Cremellon 3 Removal from Steta Donation 5 Other (Specify) | Cardens of Fai | th Cemetery | Baltimore Co., Md. | | |
| he funeral (raf. | | ** MIGHATURE OF FUNERAL SERVICE LICENSEE | | me and address of eac Zdzinski Fu 7 Eastern A | neral Home PA ve. Balto., M | d. 21221 | |
| ompletely filled in by to il, cremation, or remo event, the medica | | 23. PART I. Enter the disease, or complications that of shock, or haert failure. List only one cause IMMEDIATE CAUSE (Final disease or condition resulting in death) e. Meta. DUE TO (0) | aused the daeth. Do not enter the on each line. | | , 1 | interval Between Onset end Death | |
| the attending physician and completely filled in by the funeral director, page 5 should be detached. Mental Hygiene prior to burial, cremation, or removal. and they, or other traumatic event, the medical examiner must be notified at once. | RTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury | R AS A CONSEQUENCE OF): | | | | |
| een signed by of Health and shows any I | : MEDICAL CEI | PART II. Other algorificant conditions contributing to de | eth but not resulting in the unde | erlying cause given in F | Part i. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| ificate has less state Dept | HYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Injury limit 2 E | R/Outpatient 3 DOA 4 Nursin | 26. PLACE OF DEATH (Chec | | | |
| fter this certification with the marked, or | ву РНУ | 27. MANNER OF DEATH 1 Netural 5 Pending (Month, Day, 2 Accident Investigation | | 6c. INJURY AT WORK? 1 YES 2 NO | 28d. DEȘCRIBE NOW INJURY OCC | CURED | |
| IECTOR: After des n 28 is n | ETED E | | NJURY — Al home, ferm, street, factor :. (Specify) | y, office | 281. LOCATION (Street and Number City or Town, State) | or Rural Route Number, | |
| THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IPORTANT: It Item 28 is marked, or Item 23: | COMPL | Check only 1 CERTIFYINO PNYSICIAN: To the best of m (Check only only) 2 MEDICAL EXAMINER: On the basis of axar | | | | | |
| TO THE FUNERA be filed within 7 IMPORTANT: | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER ALCULATION 30 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE | MEDICAL RESID | ext D386 | 25 P12 | E SIGNED (Month, Day, Year) | |
| The second | | HEIDI AUERBACH, MD | OF DEATH (ITEM 27) (Type, Print) FRANCIS SOTT | r vey me | DOTE BALL | THORK, MD | |
| 0 | | DEC 14 1990 Julia David | S SIGNATURE | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

90

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90

3. TIME OF OEATH
6:10 P M

2. OATE OF DEATH DAY

FOR STATE REGISTRAR

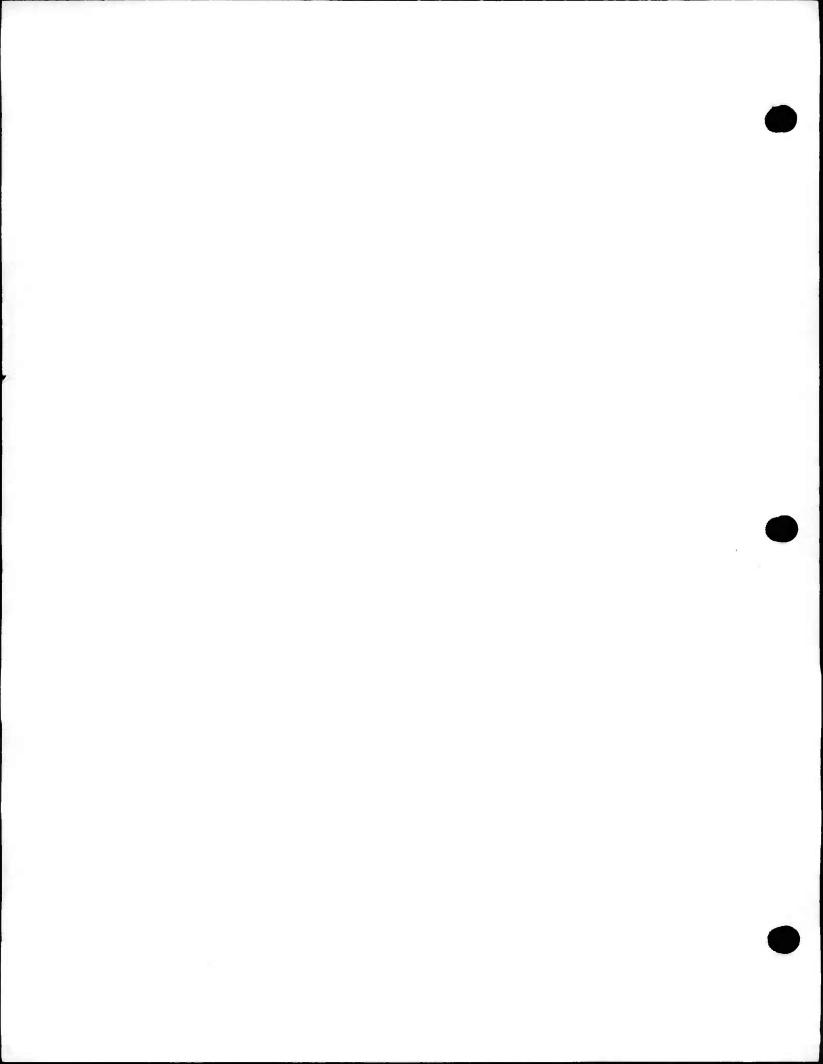
1. DECEOENT'S NAME (First, Middle, Last)
Charles

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| | | 4. SOCIAL SECURITY NUMBER 213-14-525 | | 5. SEX | 8. AGE (/ | In yrs. last b | YRS. | IF UNDE | DAYS | IF UNDER | 24 HRS. MfN. | (Mont | OF BIRTH | 11/ | 8. BIRTHPLA Country) | CE (State or Foreign |
|--|--------------|---|--------------------------|--|------------------------|----------------|-----------------|--------------------|------------|------------------------------|-----------------|------------|-------------------------------------|-----------------|-------------------------|--|
| pino | | 9a. FACILITY NAME (If not in | | / | | 10 | 11,0. | 9b. CIT | Y. TOWN | OR LOCATI | ON OF DE | - 1 | -07- | | Mary NTY OF DEATH | land |
| 3 should | RO RO | Harbour Hospital Center | | | | | | Baltimore | | | | • | | | | |
| 1, 2, | стов | RESIDENCE OF DEC | | | | | | Y, TOWN | | | | | | | | |
| physician. burial-transit permit. Pages 1, | DIRE | Maryland | IOD. COONTY | Baltimo | re | | | Balt | | | | | | | | I. INSIDE CITY LIMITS? YES KIND NO |
| E | AL | 10e. STREET AND NUMBER | | | | | | | 10 | of. ZIP COD | | | | ľ | ZEN OF WHAT | |
| n. ansit | FUNER | 2724 Yarnall Road 21227 U.S.A. | | | | | | | | | | | | | | |
| | BY FUI | 11. MARITAL STATUS 1 Never Married 2 3 Widowed 4 Divo | | 12. WAS DECEDEN FORCES? IF YES, GIVE 1 | I 🗌 YES | 2 X NO | | 13. | It yes, s | CENDENT Copecify Cuba | n, Mexica | n, Puarto | t? (Specify Yea Rican, atc.) | or No— | Black, Wi Specify: | |
| as as | ED I | 15. OEC | EDENT'S EDU | CATION | T | 18a. DECE | DENT'S | USUAL C | OCCUPAT | ION | | 168 | . KIND OF BUS | I BINESS/IND | | nite |
| for us | | Elementary/Secondary (I | | College (1-4 or 5 | +} | life. D | o NOT us | se retired.) | auring n | nost of workli | ig | | | | | |
| retained by the hospital or atti 5 should be detached for use notified at once. | COMPL | 8th Grade | | | | CA | Aste | r | | _ | | | | | ducts | |
| be detach | _ | 17. FATHER'S NAME (First, M Charles Re | | | | | | | | | | | Middle, Maiden 15kas | Surname) | | |
| should lottfled | BE | 19a. INFORMANT'S NAME (1 | | | | 19b. | MAILING | ADDRES | S (Street | | | | ber, City or Town | n. State. Zic | Code) | |
| e retained 5 should notified | 2 | Josephine F | . Reme | ikas | | 1 | | | | | | | ore, Mo | , | 1227 | |
| is after deam. Page to may be in by the funeral director, page removal. | | 20a. METHOD OF OISPOSIT | ION | | 20b. | PLACE OF | OISPOS | SITION (N | lame of c | emetery, crer | natory or | | 20c. LO | CATION — | City or Town, | Stata |
| rage o may il director, pa ner must b | | 4 Donation 5 Other | (Specify) | | Me | adow | ridg | | | ial I | | | Ва | altim | nore | |
| e funeral dir s. examiner | | 21. SIGNATURE OF FUNERA | 1 1 | 10 | | | | | | and adone | | | al Home Inc. | | | |
| arrer dea by the fur moval. Ical exa | | 11.7 | THE PERSON NAMED IN | oleman | | | | | 4107 | 7 Will | cens | Ave | nue, B | altin | nore, | Md. 2122 |
| tely filled i mation, or | | 23. PART I. Entar tha d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | aart fellure. | a. Me | las on e | ech lina. | <u>_</u> | a | | node of dy | | | | retory an | reet, | Approximate interval Between Onaet and Deat |
| in certificate be ex- ending physician a Hygiene prior to or other traum | ERTIFICATION | Sequantielly liet condit if any, leeding to imme cause. Enter UNDERLY CAUSE (Disease or Inju that initiated events resulting in death) LAS | diete ING Iry | c | | CONSEOU | | | | | | | | | | |
| s that the deal ned by the att th and Menta any injury. | DICAL C | PART II. Other algolifica | ent condition | e contributing to | death b | ut not rea | aulting i | in the u | ınderiyi | ng cauee | given in | Part I. | 24a. WAS AN PERFOR | MEO? | AW | TRE AUTOPSY FINDINGS ALABLE PRIOR TO MPLETION OF CAUSE |
| een sign of Hea | × | | | | | | | | | | | | 1 🗍 YES 2 | _ NO | | DEATH? YES 2 NO |
| The law the has bate Dept. | IAN: | 25. WAS CASE REFERRED T | O MEDICAL | | | | | | 26. | PLACE OF D | EATH (C | eck enly o | ne) | | | |
| bificate h e State l | SICI | EXAMINER? | | HOSPITAL: | ☐ ER/Outp | petient 3 | DOA | OTHE 4 - Nu | | ome 5 🗆 R | aldenca | 6 🗆 Oth | er (Specify) | | | |
| Mer this certification with the marked, or | ву РНҮ | 27. MANNER OF DEATH 1 Netural 5 2 Accident | Pending Investigation | 26a. DATE O (Month, i | F INJURY Day, Year) | | 28b. TIM INJ | IE OF JURY M | V | NJURY AT YORK? YES 2 [|] NO | 26d. DE | SCRIBE HOW I | NJURY OC | CURED | |
| . OR ATTENDING PHYSICIAN: The DIRECTOR: After this certificate hours after death with the State item 28 is marked, or Item | ETED B | 0 0 0 0 1 1 1 1 | Could not be determined | 28e. PLACE building | OF INJURY | — At hom | e, farm, : | atreet, fa | ctory, off | lice | | | CATION (Street a or Town, State) | | r or Rural Route | e Number, |
| THE HOSPITAL OR ATTENDING PHYSICIAN: THE FUNERAL DIRECTOR: After this certifica filed within 72 hours after death with the St PORTANT: If item 28 is marked, or It | COMPLE | contact only | | CIAN: To the best o | | | | | | | | | | | | d manner sa stated. |
| TO THE HOSPITAL TO THE FUNERAL Be filed within 72 h IMPORTANT: If i | BE | 29b. SIGNATURE AND TITLE | E OF CERTIFIE | -W | Thi | n | - | W |) | 29c. LJC | ENSE NU | MBER | | 29d. DAT | E SIGNED (M | onth Day, Year) |
| 2 8 9 9 8 8 9 9 | 2 | 30. NAME AND ADDRESS O | F PERSON WH | O COMPLETEO CAL | JSE OF DE | ATH (ITEM | 27) (Type | , Print) | | | -1] (| | _ | | | 100 |
| | | 31. DATE FILED (Month, Dely, | 90 | 32. REGISTR | C 1 | ATURE 4 IJJ | U | Julis | a Kilis | 1000V- | fande | الماك | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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BY FUNERAL DIRECTOR

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | PITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after de | ERAL DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fu n 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dire be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner is

TO THE H TO THE F be filed w

COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BE

9

3 Suicide

4 Homicide

a Could not be

FOR STATE REGISTRAR STATE OF MARYLAND / OEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY Jerry 90 10 son 7. DATE OF BIRTH (Month, Day, Year) 8-25 5. SEX 8. AGE (In yrs. last birthday) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. 1-09-2 9c. COUNTY OF DEATH 9b, CITY, TOWN OR LOCATION OF DEATH RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MA 10e. STREET AND NUMBER 101. ZIP CODE 10g, CITIZEN OF WNAT COUNTRY? 21201 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. If yea, specify Cuban, Maxican, Puarle Ri

1 YES 2 NO Specify: 1 Never Married 2 Married 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 124 abover 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Meiden Surname) 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 eronica 20g. METHOD OF DISPOSITION
1 Burial 2 Cremation 20b. PLACE OF DISPOSITION (Name 20c. LOCATION -- City or Town, State Burial 2 Cremation 3 Ramoval from State Donation 5 Other (Specify) 21. SIGNATURE OF TUNERAL SERVICE LICENSEE 1ar Wabash 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reaplratory arrest, ahock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition VAS Car resulting in desth) DUE TO (OR AS A CONSEQUENCE OF) Sequentisity list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events reauiting in death) LAST PART ii. Other algorificant conditions contributing to death but not reaulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 1 TYES 2 NO disease, hopertension Coronan 0 low 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Department 2 ER/Outpatient 3 DOA 1 YES 2 OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Notural М 1 YES 2 NO 2 Accident

29a, CERTIFIER LECERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and menner as stated.

28e. PLACE OF INJURY — At home, farm, atreet, factory, offica building, atc. (Specify)

29b. SIGNATURE AND TITLE OF CERTIFIER 29c, LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)

20 Ken 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

P2, REGISTRAR'S SIGNATURE DEC 14 1990

DHMH-18 Rev 1/89

34264

5:30A

3. TIME OF DEATH

10d. INSIDE CITY LIMITS?

1 YES 2 NO

Black

2-1093

Approximate

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TES 2 NO

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

37458

interval Between Onset and Death

Stars

YEAR

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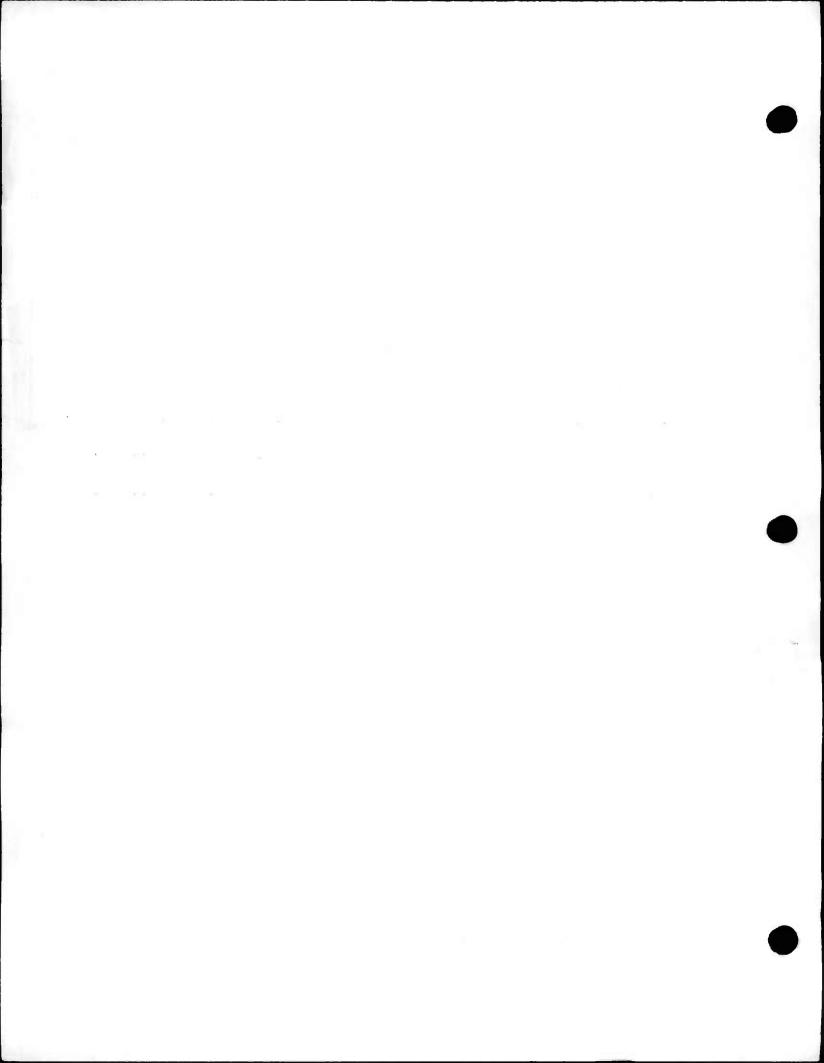
| rter death. Page 6 may be retained by the hospital or attending physician. | the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | oval. | al examiner must be notified at once. |
|---|---|---|---|
| ATTENDING PHYSICAN THE LAW INSTALLAR TO CERTIFICATE DE executed within 25 curvirs after death. Page 6 may be retain | ECTOR: After this entities has been a second and a second physician and completely filled in by the funeral director, page 5 sh | s after death with the State Dept. or have the state by the prior to burial, cremation, or removal. | n 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notif |
| to the Hospital or Attending Phys | TO THE FUNERAL DIRECTOR: After this | be filed within 72 hours after death with | IMPORTANT: If item 28 is marked |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

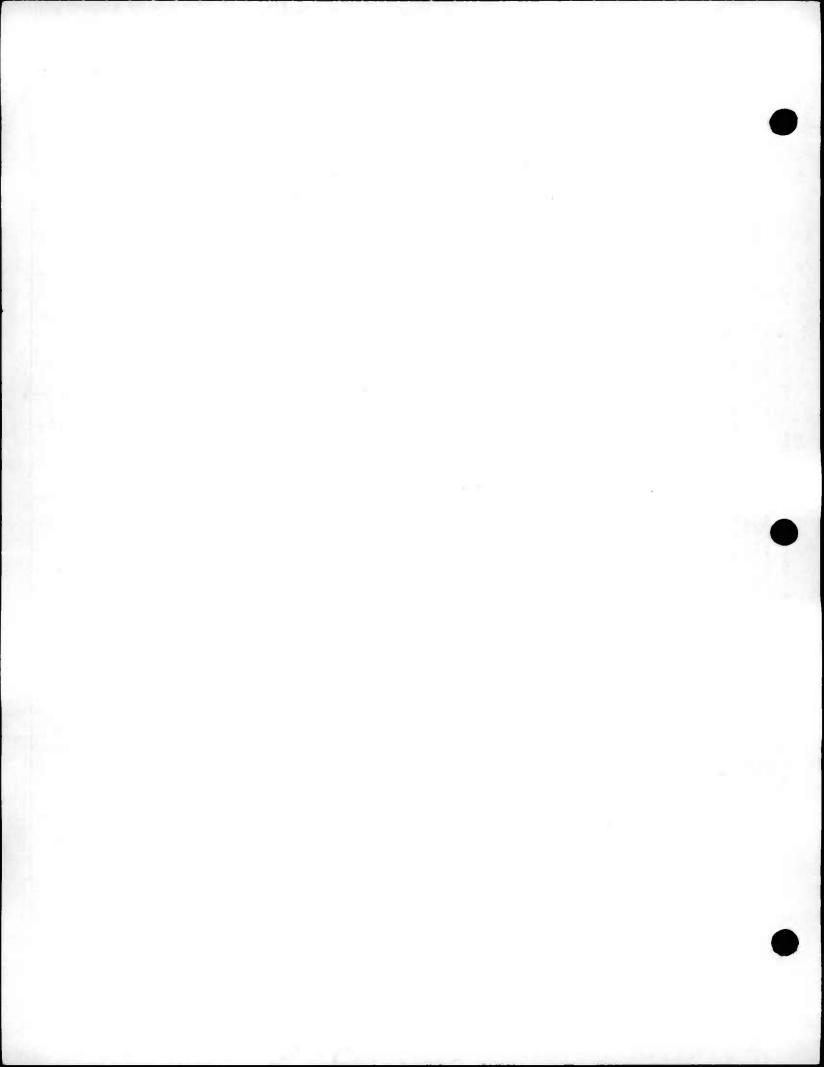
| 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | | | 2. DATE OF DEA | | | | 3. TIME OF DEATH |
|--|--------------------------|------------------------|------------------------------------|----------------|---------------|--------------|------------------------------|---------------------|--|--------------------|-----------|---------------------------|---|
| JOHN C. | ROBE | RTSON | | | | | | | 12 | 1 | 3 | 90 | 15:40 pm. |
| 4. SOCIAL SECURITY NUM | BER | 5. SEX | 6. AGE (In yrs. | ast birthday) | | DER 1 YEAR | IF UNDER | | 7. DATE OF BIRT (Month, Day, Y | TH bert | | 8. BIRTI | HPLACE (State or Foreign |
| 259-14-33 | 37 A | 1)∑ M 2 □ F | 71 | YRS. | MONTH | S DAYS | HOURA | MIN. | 12/2 | | 18 | | eeler,Ga. |
| 9a. FACILITY NAME (If not is | nstitution, give s | treet and number) | | | 9b. C | ITY, TOWN | OR LOCATI | ON OF DE | EATH | | 9c. COU | INTY OF E | |
| VA MEDI | | ENTER | | | F | ORT | HOWA | RD | | | | BAL | TIMORE |
| 10a. STATE | 10b. COUNT | r | | 10c. CIT | Y, TOW | N OR LOCA | ATION | | | | | | 10d. INSIDE CITY |
| MARYLAND | BA | LTIMORE | | | R | BALTIMORE | | | LIMITS? | | | | |
| 10e. STREET AND NUMBER | | 22 2170112 | | 1 | | | of. ZIP COD | | | _ | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| 2810 Ches | lev A | Ve. | | | | | 21 | 234 | | | 11 | ı.s. | ٨ |
| 11. MARITAL STATUS | | 12. WAS DECEDEN | TEVER IN U.S. | RMED | 1 | 13. WAS DE | CENDENT C | F HISPAI | NIC ORIGIN? (Spec | Ify Yes | | | E — American Indian, k, Whita, atc. |
| 1 Never Married 2 X | | | YES 2 MAR OR DATES | JNO | | If yes, s | pecify Cubi | n, Mexica Specif | in, Puarto Rican, a y: | 1c.) | | Spec | |
| 15. DEC | CEDENT'S EDU | CATION | 18a. | DECEDENT'S | USUAL | L OCCUPAT | ION | | 18b. KIND (| OF BUS | SINESS/IN | DUSTRY | |
| Elementary/Secondary (| - | College (1-4 or 5 | | ife. Do NOT us | se retire | nd.) | OST OF WORKI | ng | | | | | |
| 8th | | _ | | Po | lic | cema | n | | Ba: | lti | mor | e C | ity |
| 17. FATHER'S NAME (First, A | Aiddle, Last) | | | | | | - | HER'S NA | ME (First, Middle, I | /aiden | Surname) | | |
| John Ira | Rober | rtson | | | | | Flo | ra 1 | Myrtle | На | artl | ev | |
| 19a. INFORMANT'S NAME (| | | | 19b. MAILING | ADDR | ESS (Street | | | Route Number, City | | | | |
| Mr. James | s C. 1 | Roberts | on | 1256 | Me | erid | ene | Dr. | Balto | | Md. | 21 | 239 |
| 20a, METHOD OF DISPOSIT | ION | | 20b. PLAC | E OF DISPO | | | | | The second secon | | | Marin Constitution of the | own, Bteta |
| 1 ∯-Burial 2 ☐ Crematil 4 ☐ Donation 5 ☐ Othe | | oval from State | | elan | d h | /Iemo | rial | Cer | m | E | Balt | 0 | Md. |
| 21. SIGNATURE OF FUNERA | AL SERVICE LI | CENSEE | | 17.1.7111 | T | 22. NAME | AND ADDRE | SS OF FA | iller 1 | 7 | 7 | 7.7 | |
| 1 | 0 | 11.00 | | | | на | rtre | у Щ | liler | 'ur | eral | HOI | me |
| 23. PART I. Enter the c | dey. | VILLE | | | | | | | | | | | Md, 21234 |
| disease or condition resulting in death) Sequentially list condition any, leeding to immecause. Enter UNDERLY CAUSE (Disease or injusted initiated events resulting in death) LAS | ediate ring ury | b. H | O (OR AS A CONS | EDUENCE O | epl | halo | path | у | | | | | |
| PART II. Other signific | ant condition | ne contributing to | death but no | t requiting | in the | underivi | DO COURS | alven in | Part i 24n V | MARAN | AUTOPSY | . 24 | b. WERE AUTOPSY FINDINGS |
| ASHD | unt contantion | to continuoung to | , death but no | t resulting | | directly | ing cause | Aison in | P | ERFO | RMEO? | " | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | | | | 1 🗆 | YES 2 | 2X NO | | OF DEATH? |
| | | | | | | | | | — | | | | 1 TYES 2 NO |
| | | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TEXAMINER? | TO MEDICAL | HOSPITAL: | | | ОТЬ | 26. HER: | PLACE OF E | DEATH (C/ | heck only one) | _ | | | |
| 1 TES 2- NO | | 1 🖾 Inpatiant 2 | | _ | 4 🗆 | Nursing Ho | | esidence | 8 Other (Speci | ** | | | |
| | Pending Investigation | 28a. DATE O (Month, | F INJURY Day, Year) | 28b. TIA | ME OF JURY | ٧ | NJURY AT VORK? YES 2 [| _ NO | 26d. DEŞCRIBE | HOW | INJURY O | CCURED | |
| 2 Accident 3 Suicide 8 4 Homicide | Could not be determined | 28a. PLACE building | OF INJURY — A1 , atc. (Specify) | homa, farm, | street, | factory, off | lica | | 28f. LOCATION City or Town | Street , State, | and Numb | er or Aural | Route Number, |
| 29a. CERTIFIER 1 CER | TIEVING BUYO | ICIAN: To the harr | d mu kanania da i | death | a de la ce | ha dhe - 4 | | | L do the court () | -4 - | | ato d | |
| TOTACK OTHY | | EST: On the best of | | | | | | | | | | | (a) and menner ee stated. |
| 296. SIGNATURE AND TITL | OF CENTIFIE | n face | | | _ | | 29c. LIC | ENSE NU | MBER | | 29d. DA | TE SIGNE | D (Month, Day, Year) |
| tanh | a | | | | | | | 100000 | | | | | BER 14, 1990 |
| 30. NAME AND ADDRESS | PERSON WI | HO COMPLETED CA | JSE OF DEATH (I | TEM 27) (Type | e, Print) | | | | · · · · · · · · · · · · · · · · · · · | | | LICE! | min 14, 1390 |
| DR. J. VI | | | | | | | NTER | , FOI | RT HOWA | RD | , MA | RYLA | AND 21052 |
| DEC 14 | 990 | 4 32. REGISTR | AR'S SIGNATURI | | | | | | | | | | _ |



| FOR STATE REGISTR |
|--|
| 1. DECEOENT'S |
| / |
| 4. SOCIAL SECTOR OF THE PROPERTY NAMED IN COLUMN 1 |
| Pe. FACILITY N. |
| |
| 10a. STREET AN |
| 360 |
| 360 11. MARITAL ST 1 Never Mer 3 Widowed |
| - Tradward |
| Flomentary |

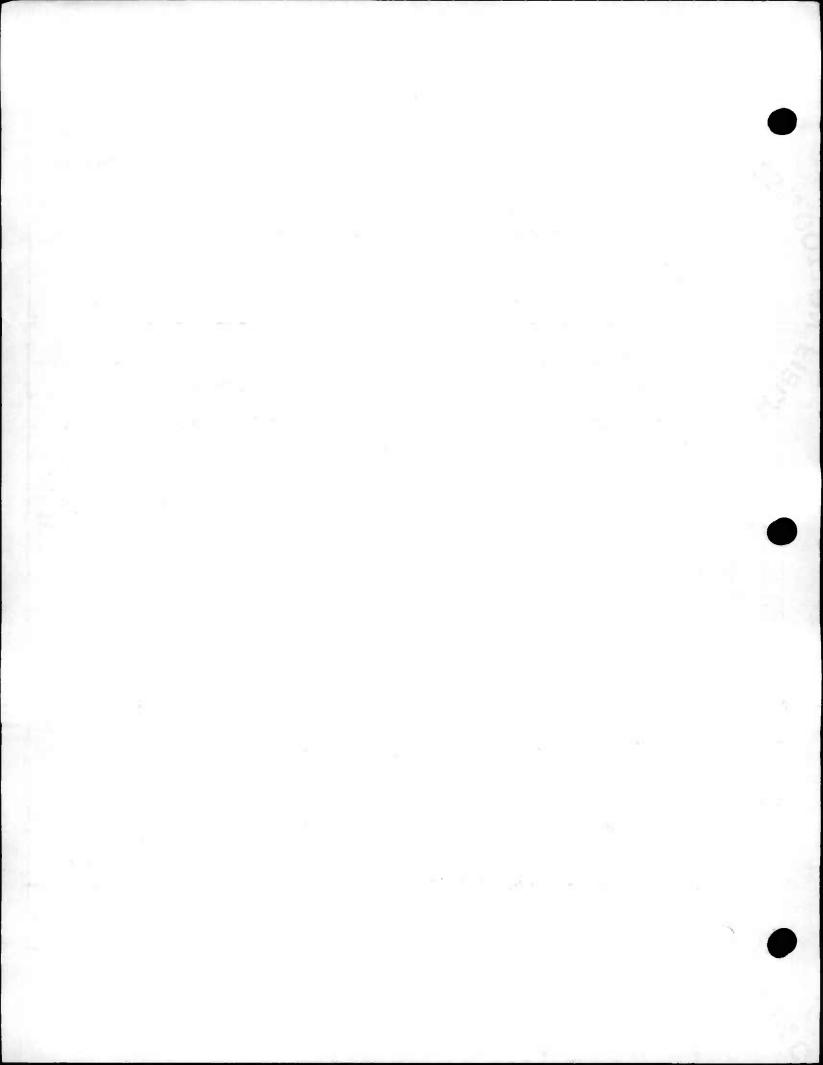
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | ATE OF DEA | IH | REG. NO. | |
|---------------|--|---|------------------------|---|----------------------|--|--|
| - Naid | 1. DECEOENT'S NAME (First, Middle, Last) | Resi | 1 | | 2. DATE MONT | E OF OEATH | 3. TIME OF DEATH |
| | 2111 5 | 5. SEX 6. AGE (In | | F UNDER 1 YEAR IF UNDER ONTHS DAYS HOURS | | of BIRTN th, Day, Ybar) | 6. BIRTNPLACE (State or Foreign Country) |
| NO. | 90. FACILITY NAME (If not institution, give atre | le Cente | | BALLIN | ON OF DEATH | 1 to oc. co | OUNTY OF DEATH |
| 15 | RESIDENCE OF DECEDENT | | | | | | |
| W / | 10s. STATE 10s. COUNTY | | 10c. CITY, | DWN OR LOCATION | | | 10d. INSIDE CITY |
| L DIRECTOR | 10s. STREET AND NUMBER | | 13 | Alliner | 10 | - In a | LIMITS? 1 YES 2 NO CITIZEN OF WHAT COUNTRY? |
| FUNERAL | 3602 Reiste | rstown | Rd | 101. ZIP COD | 1215 | 109.0 | U. S.A. |
| 5 | | 12. WAS DECEDENT EVER IN | | 13. WAS DECENDENT | OF NISPANIC ORIGI | IN? (Specify Yee or No- | - 14. RACE — American Indian, |
| B | 1 Never Merried 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES IF YES, GIVE WAR OR DAT | | If yes, specify Cube 1 - YES 2 - NO | | Rican, etc.) | Black, White, etc. Specify: |
| E | 15. DECEDENT'S EDUCA (Specify only highest grade of | | 16a. DECEDENT'S US | BUAL OCCUPATION is done during most of world etired.) | ng 16 | b. KIND OF BUSINESS/ | INDUSTRY |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+) | | =MAKE | | | |
| 00 | 17. FATHER'S NAME (First, Middle, Last) | 7 | | | | Middle, Malden Surname | 9) |
| BE (| | REID | | 1/1 | 140RE | DWAT | KINS |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | TKING | 196. MAJUNG A | DDRESS (Street and Number | r or Rural Route Nur | nber, City or Town, State, | 11. |
| 20 | 20e. METHOD OF DISPOSITION 1 | 20b. | PLACE OF DISPOSIT | ION (Name of cemetery, cre- | matory or | 20c. LOCATION | TO MODIZIS City or Town, State |
| | 4 Donation 8 Other (Specify) | H | RBUTU | SMEM | PARK | BANT | TO CO, MO |
| CAGIIII. | 21. SIGNATURE OF FUNERAL SERVICE LICE | rend HE | me | 22. NAME AND ADDRE | | north | Ano |
| | 23. PART I. Enter the diseases, or co | implications that caused | the death. Do not | | | | srrest, Approximate |
| | shock, or heart fallure. LI IMMEDIATE CAUSE (Finsi | at only one cause on ea | cn line. | 1 | | | Interval Between Onset and Death |
| 1 | disease or condition resulting in death) | ardio | CONSEQUENCE OF: | thy. | | | 2yr |
| Z | | Hyperte | 05 10 P | | | | 30+vr |
| CERTIFICATION | Sequentistiy list conditions, If sny, leading to immediate ceuse. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | |
| IFIC | CAUSE (Disesse or Injury that initiated events | DUE TO (OR AS A | CONSEQUENCE OF): | | | | |
| ERT | resulting in desth) LAST | | | | | | |
| | PART II. Other significant conditions | contributing to death bu | it not resulting in | tha underlying cause | given in Part i. | 24a. WAS AN AUTOPS PERFORMED? | |
| EDICAL | Disbotos | Nellitus | | | | 1 TES 2 NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 2 | | | | | | | 1 - YES ONO |
| HYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PLACE OF I | DEATH (Check only o | one) | |
| rsic | | HOSPITAL: 1 Inpatient 2 ER/Output | | OTHER: | lesidence 8 🗆 Ott | ver (Specify) | |
| 惟 | 27. MANNER OF DEATN 1. Netural 8 Pending | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJUI | OF 28c. INJURY AT WORK? M 1 YES 2 | | EŞCRIBE NOW INJURY | OCCUREO . |
| ED B | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — Al home, farm, str | set, factory, office | | CATION (Street and Num by or Town, State) | nber or Rural Route Number, |
| ET I | 290. CERTIFIER | IAN: To the best of my knowle | des death assured | | | | |
| COMPLETED | 0001 | | | | | | to the couse(e) and manner se stated. |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIER | 1 | nD | 29c. LIC | ENSE NUMBER | 29d. 1 | DATE SIGNED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATN (ITEM 27) (Type, F | (ma) | p 1.1 | | 100 31-5 |
| | 31. DATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGN | TURE | Volte St | Balt | more, 1 | MM 81302 |
| | DFC 14 1990 | guha Davidson | Naviana | | | | |



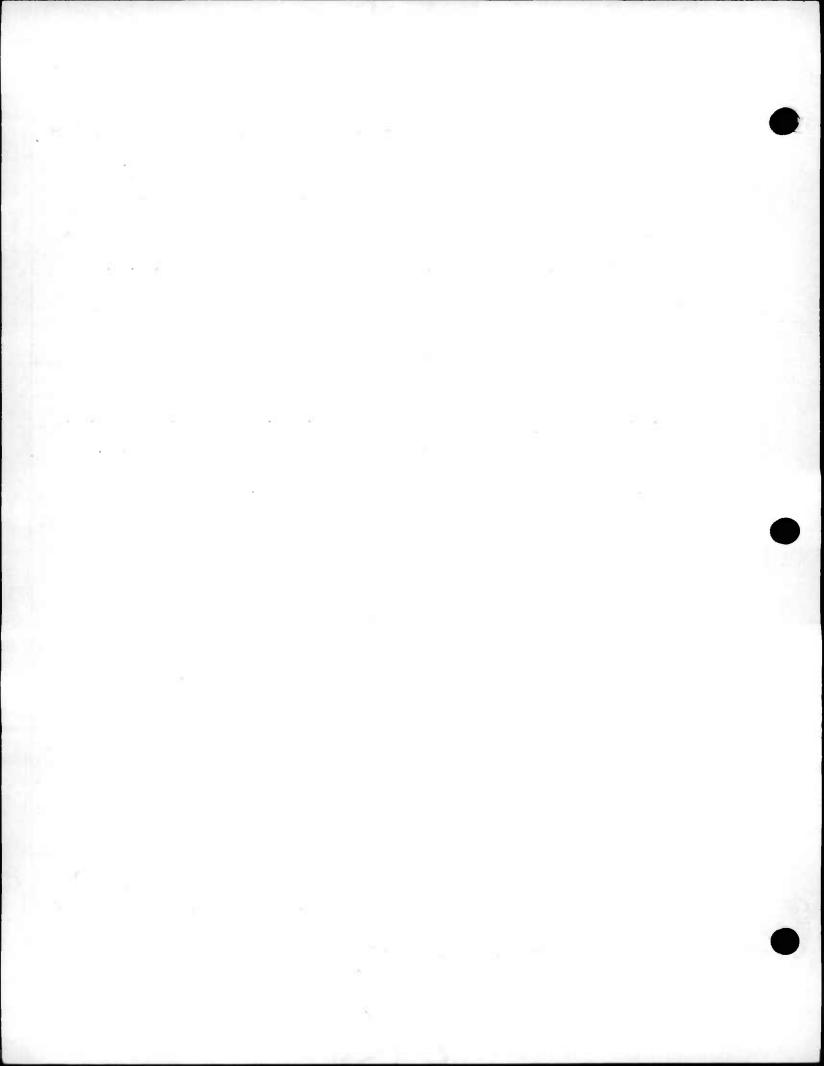
| | | 4. SOCIAL S |
|--|-------------------------------------|---|
| -3146 ding physician. s the burist-transit permit. Pages 1, 2, 3 should | TO BE COMPLETED BY FUNERAL DIRECTOR | 153-4 Se. FACILITY C PRESIDEN 10s. STATE Md 10s. STREET 45 11. MARITAL 1 Never 3 Widow |
| BALTIMORE, MARYLAND 21203-3146 tet death. Page 6 may be interied by the hospital or attending physicilite tuneral director, page 5 should be detached for use as the burily ask. | TO BE COMPLETED | Elements Hig 17. FATHER1 18e. INFORM Mrs. 20e. METHO 1 SE Surfal 4 Densit 21. SIGNAPO |
| inours at my filled in by nation, or nemo, | | 23. FART IMMEDIAT disease o resulting |
| gue that the down certificate be executed with magnet by the attenting physician and complete in signed by the attenting physician and complete in signed by the attenting physician prior in buttial, one in these traumstic event lower any Injury, or other traumstic event | IN: MEDICAL CERTIFICATION | Sequential of any, lead cause. En CAUSE (0) that initial resulting |
| TISION OF VITAL PROTECTION OF WITHOUT PROTECTION And THE CHARLE THE CHARL PROTECT PROT | LETED BY PHYSICIAN: ME | 25. WAS CALEXAMIN |
| DIV HOSPITAL OR / FUNERAL DIRE WITHIN 72 hours TANT: If Item | BE COMPLE | 29a. CERTH (Check ane) |
| H 3HT OT H 3HE H No filed w | O BE (| 29b. SIGNA |
| | 2. 45. | |

| | 1 - STATE REGISTRAR | STATE OF MA | RYLAND / DEI | | MENT OF H | | | TAL HYGIEN REG. NO | | 90 . | 34261 |
|---------------|---|---|---|---------------------------|--|--|---------------------------------------|--|------------|---------------------|---|
| | 1. DECEDENT'S NAME (First, Mixtus, Last, John | n Patrick | Reilly | | | | | NATE OF DEATH DON'TH DEATH DON'TH DEATH DE | 7 | YEAR 3. | 3:30P. M |
| | 4. SOCIAL SECURITY NUMBER 153-42-7001 | 1 X M 2 F | AGE (In you leat birth | | UNDER 1 YEAR NYME DAYN | HOURS A | en (| MOUTH, Day, War) | 950 | Country) | to. Md. |
| 1000 | Se. FACILITY NAME (If not institution, give | street and number) | | 91 | L CITY, TOWN O | R LOCATION | | | 9c. COU | NTY OF DEAD | |
| DIRECTOR | Church Hospi | tal | | | Balt | imore | | | _ | City | |
| REC | 10s. STATE 10b. COUN | TY | | CITY, T | OWN OR LOCAT | ION | | | | 10 | d. INSIDE CITY LIMITS? |
| | Md. | Baltimor | e | | | erstp | wn | | 1 | _ | ☐ YES 2 🔯 NO |
| FUNERAL | 45 Brookshire | Drive | | | 106 | 21P CODE 2 1 | 1136 | | 10g. Cit | | SA |
| ВУ | 11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 📉 Divorced 12. WAS DECEDENT EVER IN U.S. AB FORCES7 1 ☐ YES 2 ☐ WITHOUT STATES IF YES, GIVE WAR OR DATES | | | | 13. WAS DEC If yes, spe 1 YES | ENDENT OF P HOTEL Cubers, P 2 XX 940 | RISPANIC O Mexican, Pu Specify: | RIGIN? (Specify Ye erto Rican, etc.) | s or No- | Specify: | American Indian, Thite |
| COMPLETED | (Specify only highest grade completed) (Si Ejementary/Secondary (0-12) College (1-4 or 5+) | | | not of work AOT uses n | ual occupation desired in the control of the contro | IN at of working | | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| OME | High School 77. FATHER'S NAME (First, Mixelle, Last) | | _ | 00 | IKCL | 18. MOTHER | TS NAME (F | Trut, Middle, Maider | n Sumama) | | |
| BE C | Joseph B. Re | eilly Jr. | | | | 2000 | | C. Price | | | |
| 0 B | 15s. INFORMANT'S NAME (Type/Print) | | 1000000 | | | | | Number City or Xx | | | |
| | Mrs. Mary C. Rei | lly | 20b. PLACE OF D | | | | | e May, N. | | 204 Otty or Town | Elete |
| | 1 ∰ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify) | movel from State | other pisos) | | ral Ce | - | | 200. 0 | | imore, | |
| | 21. SIGNAPORE OF FUNERAL SERVICE I | | | -1100 | 22. NAME AN | D ADDRESS | OF FACILIT | | 24 Da | datam | torm Dd |
| | Fame B | Elin | 4 | | Eline | Funer | al H | ome Reis | sters | town, | Md. 21136 |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | PROFOUN DUE TO (C | OF AS A CONSEQUENCE OF AS | CEOFE | | | | | | | |
| MEDICAL CER | PART II. Other significant condition IV DRUG ABUSE | ons contributing to d | leeth but not resul | iting in | the underlyin | g cause giv | en in Pari | | PRIMED? | 0 | ERE AUTOPSY FRIDINGS WALABLE PRIOR TO OMPLETION OF CAUSE F DEATH? YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PI | ACE OF DEA | TH (Check o | inty one) | | | |
| SIC | EXAMINERY 1XXYES 2 □ NO | HOSPITAL: | ER/Outpatient 3 🗆 t | | OTHER: | e 5 🗆 Hesi | dence & 🗆 | Other (Specify) | | | |
| BY PH | 27. MANNES OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28s. DATE OF 8 (Month, Day 11/26/ | | b. TIME (| IY WC | HURY AT HURY YES 2 [] | 1 | ROBABLE | | | VERDOSE |
| ED | 3 Suicide 6 Could not 8 | building, # | INJURY — At home, to (Specify) | tann, str | eet, factory, offic | • | 281 E | LOCATION (Stree City or Rwn, Stat SAL/TIMOR | e and Mumb | AVER. | CITY JAIL |
| COMPLET | pursue, only | SICIAN: To the best of n | | | | | | | | | and manner as stated. |
| TO BE C | 290. SIGNATURE MIC TITLE OF CERTIF | 200- | | | | 100000000000000000000000000000000000000 | SE NUMBES CME | | 29d, D/ | 12-8- | Arrom, Day, Year) 90 |
| | Ann M. Dixon, | M.D. | 111 | | | Balt | o., M | id. 212 | 01 | | |
| | 1 4 1990 | gram wavide | on-Randall | | | | | | | | |



| FOR 1 - STATE REGISTRAR | STATE OF MA | | RTMENT OF H | | MENTAL HYGIENE REG. NO. | 91 | J 34268 |
|--|---|-------------------------------------|--|--------------------------------|--|------------------|---|
| 1. DECEDENT'S NAME (First, Middle, I | | | S.f | fran | 2. DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF CEATH |
| 4. SOCIAL SECURITY NUMBER 217-40-5907 | 1 🗆 M 2 🖰 F | AGE (In yrs. last birthday) 83 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 5-16-07 | 8. BIR | THPLACE (State or Foreign intry) d |
| 9a. FACILITY NAME (If not institution, Summit Nursing RESIDENCE OF DECEDEN | g Home | | | nsville | | Balti | |
| 10a. STATE 10b. CC | | | tonsvill | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO |
| 100. STREET AND NUMBER 98 Smithwood | Ave.—Baltimo | re. Md. | 101 | ZIP CODE | 8 | 10g. CITIZEN OF | F WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR | VER IN U.S. ARMED YES 2 NO | If yes, sp | ENDENT OF HISPA | NIC ORIGIN? (Specify Year an, Puerto Rican, stc.) | or No— 14, R/ | ACE — American Indian, ack, White, atc. |
| 15. DECEDENT'S (Specify only highest Elementary/Secondary (0-12) | | 16a. DECEDENT'S | B USUAL OCCUPATION work done during mo | N at of working | 166, KIND OF BUSI | NESS/INDUSTRY | |
| N/A 17. FATHER'S NAME (First, Middle, Las | N/A | Hous | ewife | 16. MOTHER'S NA | N/I | urname) | |
| Louis Otto 198. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | 3 ADDRESS (Street a | | y Pickett Route Number, City or Town, | State, Zip Code) | 21090 |
| Miss. C. Jean State Stat | | 432 | Hillview | DrApt | . 204 Balt | | hicum, Md. |
| 1. ☐ Burial 2 | | other place) | Park Cem | etery | Ва | ltimor | • |
| G. Truman | Schwab | | 351 | Freder | Md. 21229 | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | b. DUE TO (OF c. Ases | R AS A CONSEQUENCE O | opo n fi | brille | ation | | Onset and Dea |
| PART II. Other significant cond | litiona contributing to de | ath but not resulting | in tha underlying | cause given in | Part I. 24e. WAS AN PERFORI | ED? | 44b. WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDIC EXAMINER? 1 YES 2 NO | HOSPITAL: | R/Outpatient 3 DOA | OTHER: | ACE OF DEATH (C | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investige | 28a. DATE OF IN. (Month, Day, | JURY 28b. Till | ME OF 28c. INJ | | 6 Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCURED | |
| 3 Sulcide 8 Could no 4 Homicide determin | 28e. PLACE OF II | NJURY — At home, farm, (Specify) | street, factory, offic | | 281. LOCATION (Street ar City or Town, State) | d Number or Run | al Route Number, |
| | PHYSICIAN: To the best of my | | | | | | e(a) and menner as stated. |
| 296. SIGNATURE AND TITLE OF CER | TIFIER LOW | e m.J | D. | 29c. LICENSE NU | MBER 170 | 29d. DATE SIGN | ED (Month, Day, Year) |
| J.E. ROWE | N WHO COMPLETED CAUSE | ret N. | ursin | g Hon | ne Bal | to M | 1.21228 |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SIGNATURE | | 100 | | | |





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DIVISION OF VITAL RECORDS, P.O. BOX 13146,

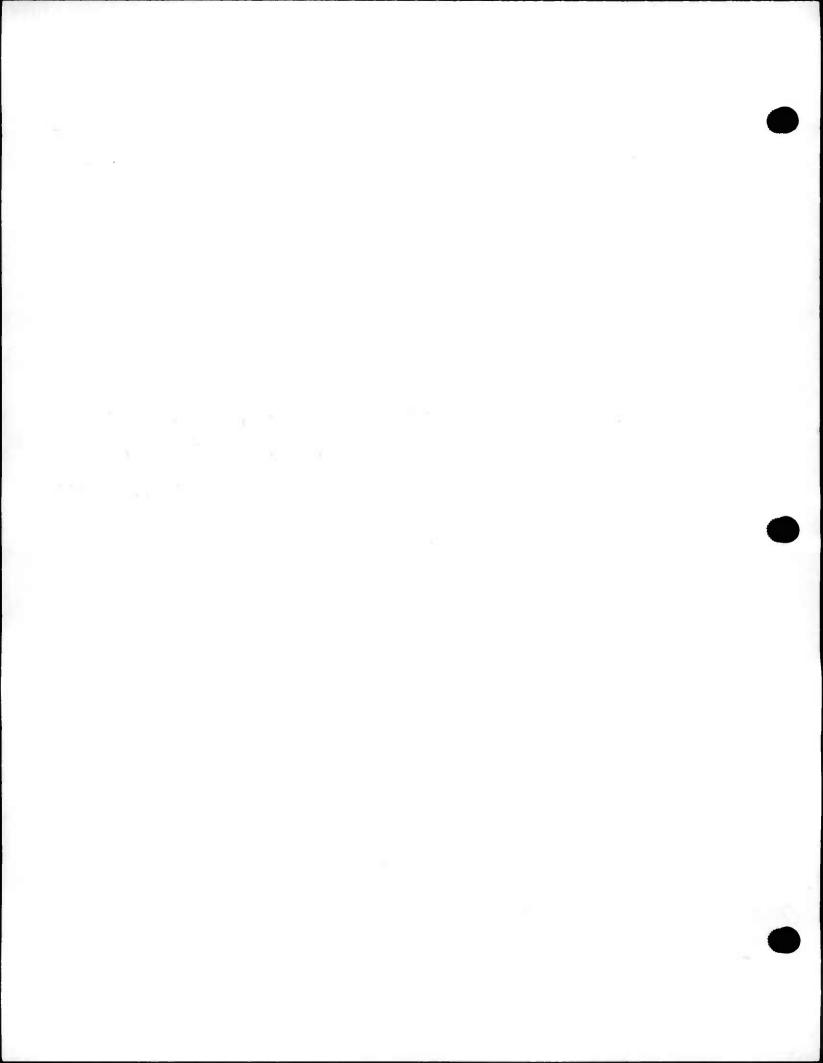
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| y the attending | nd Mental Hy | inimy or other traumatic event the medical examiner must be notified |
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1 - FOR STATE REGISTRAR

| | REGISTRAR | | CERTIF | | DEATH | REG. NO | | |
|---------------------|--|--|---|--|---|---|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | "SFIRE Ler | n Joseph | ine Se | iler | 2. DATE OF DEATH 2 | 2-12-9 | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 8. A | GE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | BIRTHPLACE (State or Foreign |
| | | 1 M 2 D | 200 | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | | Country) |
| | 193-14-6399 90. FACILITY NAME (If not institution, give | | 66 YRS. | | | 05-24-1 | | <u>ennsylvania</u> |
| ~ | | / | 4 | | OR LOCATION OF DE | | 9c. COUNTY | OF DEATH |
| ğ I | Good Samart | ian Hospit | al " | Balti | more Ci | ty | | |
| ECTOR | RESIDENCE OF DECEDENT | pr v | 10e. CD | TY, TOWN OR LOCA | | | | 10d. INSIDE CITY |
| DIR | Maryland | | | | | L | | 1 VES 2 NO |
| | 10a. STREET AND NUMBER | | | Bar (1 | more Ci | τy | 40- 0174751 | OF WHAT COUNTRY? |
| RAL | | :11 D 1 | | " | 2 0 0 | | | |
| FUNE | 1628 Roundh | | | | 21218 | | | SA |
| 교 | 1 Never Merried 2 Merried | 12. WAS DECEDENT EVE FORCES? 1 Y | ES 2 NO | If yes, e | pecify Cuben Mexicer | | e or No— 14. | RACE — American Indian, Black, White, atc. |
| β | 3 Wildowed 4 Divorced | IF YES, GIVE WAR O | R DATES | 1 🗆 YE | S 2, NO Specify | | | White |
| | 15. DECEDENT'S E | DUCATION | 46. DECEDENT | S USUAL OCCUPAT | 1011 | 16b, KIND OF BU | 000000000000000000000000000000000000000 | The state of the s |
| ETE | (Specify only highest gr | ade completed) | (Give kind of | work done during m | ost of working | 166. KIND OF BU | SINESS/INDUS | INT. |
| _ | Elementary/Secondery (0-12) 12th | College (1-4 or 5+) | | | | Call. | | A |
| сомь | | | LOTT | ection | | | | Agency |
| 응 | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Malden | Sumame) | |
| BE | John Flahe | r.ry | | | Mary | | | |
| 0 | 190. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Tox | | |
| - | John J. Seil | er | | | | ad, Bal | to., N | ID 21218 |
| | 20a. METHOD OF DISPOSITION 1 ☐ Burlet 2 📉 Cremetton 3 ☐ R | amoval from State | 20b. PLACE OF DISPO | | | | CATION — City | |
| | 4 Donation 5 Other (Specify) | | Metro C | remator | cy, Inc. | Ba] | Ltimor | e, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE Mon | He | 22. NAME / | AND ADDRESS OF FAC | LILITY . | £ 1/10 | J J |
| | George E. | MacNabb | | orei | matton S | ociety o | oi Mar | yrand |
| | 0 | | | 299 | rrederi | ck Rd., I | sarto. | , MD 21228 |
| | 23. PART I. Enter the diseases, a shock, or heart fallu | re. List only one ceuse o | n each line. | not enter the m | ode or dying, such | i as cerdiac or reep | eratory arrest | interval Between |
| | IMMEDIATE CAUSE (Finsi | 11- | 1 1 TIM | - 1 | Mal | 1/1 /1 | | Oneet and Death |
| | disease or condition resulting in death) | a. 19011 | 15/19/1 | Cm | All Cell | CA OLI | ung | |
| | | DUE TO (OR | AS A CONSEQUENCE | OF): | | 1 | | |
| Z | Sequentially list conditions, | b | | | | V | · · | |
| E | if any, leading to immediate | OUE TO (OR / | AS A CONSEQUENCE | OF): | | | | |
| 2 | cause. Enter UNDERLYING CAUSE (Disease or Injury | c | | | | | | |
| H | that initiated events resulting in death) LAST | DUE TO (OR / | AS A CONSEQUENCE (| OF): | | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | _ | |
| | PART II. Other significant condit | tions contributing to deal | th but not resulting | In the underlyle | ng cause given in | Part i. 24a, WAS AI | VAUTOPRV | 24b. WERE AUTOPSY FINDINGS |
| DICAL | 100 | | an bat not rooming | in the discord | ng couse given in | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | | D D 41 | | | | 1 (F) YES | 2 NO | OF DEATH? |
| ME | | DDM | | | | | | 1 YES 2 MO |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.





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BALTIMORE, MARYLAND 21203-3146

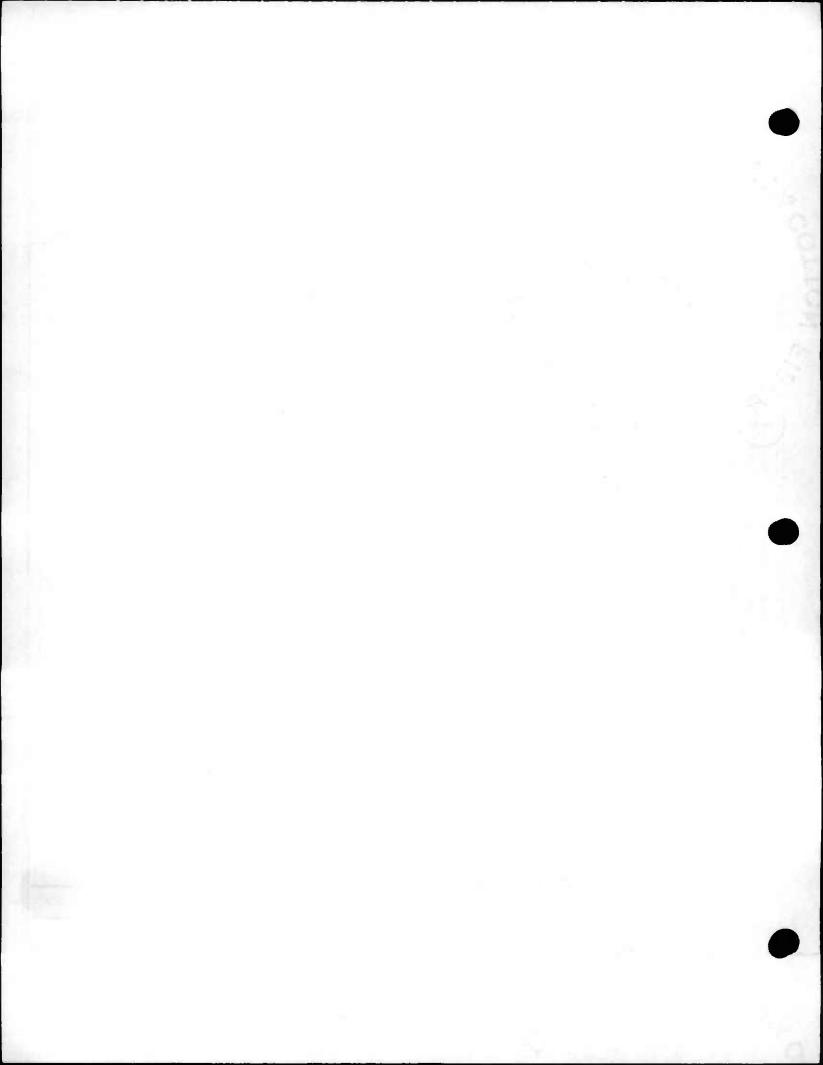
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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| DIVISION OF VITAL RECORDS, F.O. BOX 13149, | TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 2. Jours after death. Page 6 may a waiting by the hospital or announced by the hospital | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely Tiled in by the funeral directs, owned support the transfer of the funeral directs owned to the funeral directs. | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation. or removal, | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| 1, OECEDENT'S NAME (First | , Middle, Last) | | | | | | | | | OF DEATH | | VE45 | 3. TIME OF DEATH | |
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| 12th Grad | | | " | Wend | ly'S | Res | tau | rant | : | | | | | |
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| Daniel | | Stavis | | | | | Man | rу | | W | 1111 | S | | |
| 19e. INFORMANT'S NAME (| Type/Print) | | | 19b. MAILIN | G ADDRESS (| Street and | d Number | or Rural Ro | oute Num | ber, City or Tow | rn, State, Zi | p Code) | | |
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| 20a. METHOD OF DISPOSIT | | ACCOPING SALES AND ACCOUNT | | | SITION (Name | of ceme | etery, cremi | ntory or | | 20c. LC | CATION - | City or T | own, State | |
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| 21. SIGNATURE/OF FUNERU | L SERVICE IS | CENSEE / A A | | | 22. N/ | AME AND | DADDRES | S OF FAC | H CTV | | | | | |
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32. REGISTRAR'S SIGNATURE who Saindson-Randell

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| | after death. Page 6 may be retained by the hospital or attending physician | by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sh |

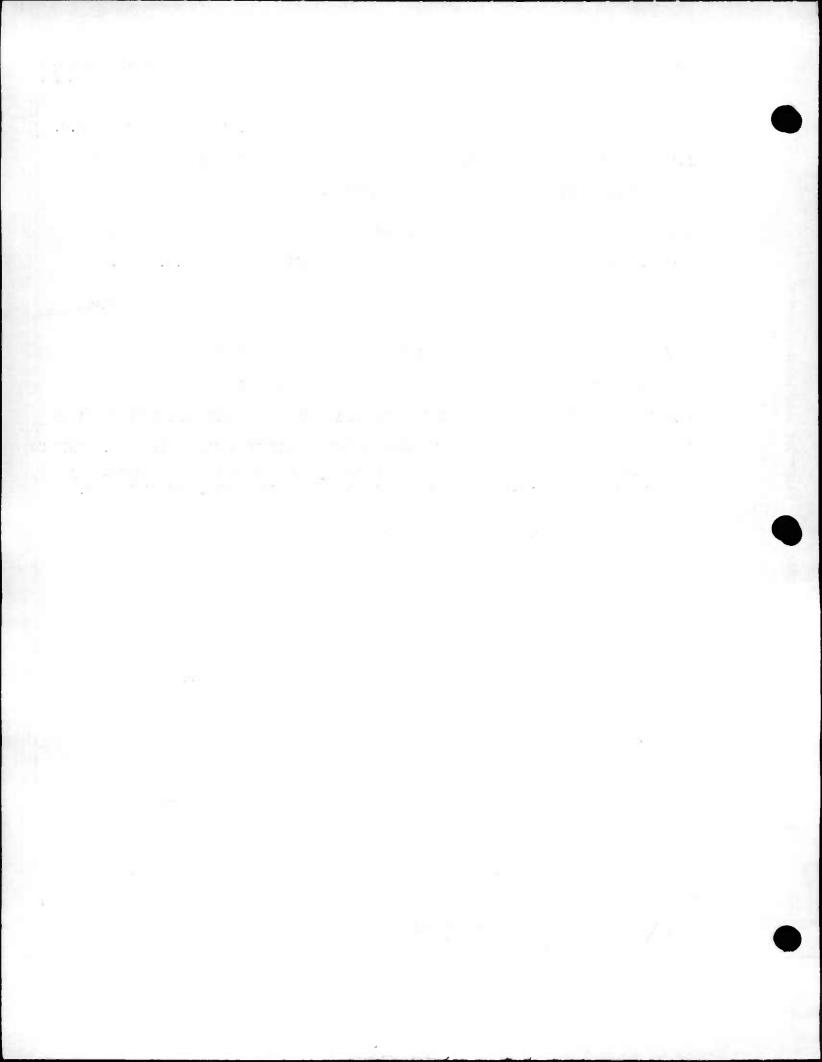
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

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| death cert | attenting | ental Mydie | Iry, or oth |
| the death cert | v the attenting | d Mental Hygie | injury, or ott |
| that the death cert | ed by the attenting | h and Mental Hygie | any injury, or oth |
| res that the death cert | signed by the attenting | lealth and Mental Hygie | ws any injury, or ott |
| requires that the death cert | en signed by the attenting | of Health and Mental Hygie | shows any injury, areott |
| law requires that the death cert | is been signed by the attenting | ept. of Health and Mental Hygie | 23 shows any injury, areott |
| The law requires that the death cert | te has been signed by the attenting | ite Dept. of Health and Mental Motie | эт 23 shows any injury, quoti |
| AN: The law requires that the death cert | ificate has been signed by the attenting | State Dept. of Health and Mental Mygie | r item 23 shows any injury, or oth |
| SICIAN: The law requires that the death cert | certificate has been signed by the attenting | h the State Dept. of Health and Mental Hygie | d, or item 23 shows any injury, quoti |
| PHYSICIAN: The law requires that the death cert | this certificate has been signed by the attenting | with the State Dept. of Health and Mental Hygie | rked, or Item 23 shows any injury, arott |
| ING PHYSICIAN: The law requires that the death cert | After this certificate has been signed by the attenting | leath with the State Dept. of Health and Mental Moje | marked, or item 23 shows any injury, apoit |
| ENDING PHYSICIAN: The law requires that the death cert | DR: After this certificate has been signed by the attenting | ter death with the State Dept. of Health and Mental Migig | Is marked, or item 23 shows any injury, areoft |
| ATTENDING PHYSICIAN: The law requires that the death cert | ECTOR: After this certificate has been signed by the attenting | rs after death with the State Dept. of Health and Mental Migie | n 28 is marked, or item 23 shows any injury, or oth |
| OR AITENDING PHYSICIAN: The law requires that the death cert | DIRECTOR: After this certificate has been signed by the attenting | hours after death with the State Dept. of Health and Mental Higie | item 28 is marked, or item 23 shows any injury, or oth |
| PITAL OR ATTENDING PHYSICIAN: The law requires that the death cert | RAL DIRECTOR: After this certificate has been signed by the attenting | 1 72 hours after death with the State Dept. of Health and Mental Hygie | : If item 28 is marked, or item 23 shows any injury, quoti |
| IOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert | UNERAL DIRECTOR: After this certificate has been signed by the attenting | rithin 72 hours after death with the State Dept. of Health and Mental Hygie | ANT: If item 28 is marked, or item 23 shows any injury, quoti |
| HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cert | HE FUNERAL DIRECTOR: After this certificate has been signed by the attenting | ed within 72 hours after death with the State Dept. of Health and Mental Moje | DRTANT: If item 28 is marked, or item 23 shows any injury, quoti |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the deam certificate be executed within the article of may be retained by the mosping | THE FUNERAL DIRECTOR: After this certificate has been signed by the attenting | he filed within 72 hours after death with the State Dept. of Health and Mental Moje | IMPORTANT: If item 28 is marked, or item 23 shows any injury, apother traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA | | | MENTAL HYGIEN | | 50 34271 |
|--|--|--|---------------------|-----------------------|--|------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| ALFRED MAYOR | SMITH | | | | DEC. 11th | | 0 10:56 A.M. M |
| 4. SOCIAL SECURITY NUMBER | | MC | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) |
| 212 36 8040 9a. FACILITY NAME (If not institution, give | 1 X M 2 D F 5 | 2 YRS. | | OR LOCATION OF OE | JULY 25,1 | | MARYLAND Y OF DEATH |
| SINAI HOSP | | | BALTI | | AIR | 96. COUNT | Y OF DEATH |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT | Υ | 10c. CITY, T | TOWN OR LOCAT | ION | | - | tod. INSIDE CITY |
| MARYLAND | | BAI | TIMORE | | | | LIMITS? |
| 10s. STREET AND NUMBER | | | 101 | , ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? |
| 1610 N. FULTON A | VENUE | | | 21217 | | U.S. | OF A. |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 TYES IF YES, GIVE WAR OR O | 2 NO | If yes, sp | | IC ORIGIN? (Specify Yan, Puerto Rican, atc.) | a or No 1 | 4. RACE — American Indian, Black, White, etc. Specify: BLACK |
| 15. DECEDENT'S EOU (Specify only highest grad | JCATION e completed) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | WAL OCCUPATION | ON st of working | 16b, KIND OF BU | ISINESS/INDU | STRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | 000000 | | |
| N/A 17. FATHER'S NAME (First, Middle, Last) | | LABO | JKEK | 10 MATHERIO | CONSTR | | 4 |
| LESTER DORSEY | | | | | H SMITH | i Surname) | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AL | DDRESS (Street a | | Oute Number, City or Toy | vn. State. Zip C | Code) |
| MRS. SARAH GAINES | | 3916 B | FORDLE | IGH AVEN | UE BALTIM | ORE M | ARYLAND 21215 |
| 20a, METHOD OF DISPOSITION 1 Description Burlel 2 Cremation Rer 4 Donation 5 Other (Specify) | noval from State | b. PLACE OF DISPOSITI | ION (Name of cer | metery, crematory or | 20c. LC | OCATION CI | ity or Town, State LLE, MD. BALTO C |
| 21. SIGNATURE OF FUNEDAL SERVICE L | | LOIDIN OIL | 22. NAME AI | ND ADDRESS OF FA | CILITY | | 21215-6393 |
| · agues | Jury | m | | | | | TIMORE, MD. |
| 23. PART I. Enter the diseases, or shock, or heert fellure IMMEDIATE CAUSE (Finel disease or condition resulting in death) | LUN (| ech line. | NCE | | n as certaise or resp | metory sires | st, Approximate Interval Between Onset and Death |
| Sequentially list conditione, if smy, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | A CONSEQUENCE OF): | | | | | |
| PART II. Other significent condition | ne contributing to death i | but not resulting in | the underlyin | g ceuse given in | Part I. 24s. WAS A | N AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| | | | | | | PRMED? | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | LACE OF DEATH (Ch | eck only one) | | |
| 1 TYES 2 NO | 1 Inpetient 2 ER/Out | patient 3 DOA 4 | OTHER: | ne 5 🗆 Rasidence | 8 Other (Specify) | | |
| 27. MANNER OF DEATH 1 Neturel 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| SA MC | PURY AT DRK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCL | JRED |
| 3 Suicide 8 Could not be determined | 28e, PLACE OF INJUR | Y — At home, term, etre | eet, factory, offic | :0 | 28f. LOCATION (Street City or Town, State | | v Rural Route Number, |
| one) | SICIAN: To the best of my know | | | | | | d. , cause(a) and manner as stated. |
| 296 GIGNATURE AND TITLE OF CERTIFI | | A h n | A . | 29c. LICENSE NUI | | - | SIGNED (Month, Day, Year) |
| 30, NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF D | Affected at the B | ling W | D 29 | 1071 | > 1 | 12-12-90 |
| R. KRISHNAN | MD 82 | | TAW | ST # | 2300/ | SALT | 1 MORE 21201 |
| 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S SIG | NATURA DE | | | | | |



BALTIMORE, MARYLAND 21203-3146

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HE HOSPITAL OR ATTENDIN.
""INFRAL DIRECTOR: After the "To".

To hours after death "In".
"" 28 Is no.

1 - FOR STATE REGISTRAR 34272 90 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. OECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 3. TIME OF DEATH Ε. William Swindell Jr. 12-11-90 6:33PM 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, 1997) 05 - 11 - 54 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 220-68-3779 DAYS HOURS 1 X X 2 - F 36 YRS D.C 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Baltimore City Johns Hopkins Hospital RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD. BALTIMORE, MD. 1 □ X VES 2 □ NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 125 COLVIN ST. APT-9F 21202 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 💢 Merried If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: Specify: BLACK BY 3 Widowed 4 Olvorced COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Elementary/Secondary (0-12) College (1-4 or 5+) UNEMPLOYED 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) WILLIAM E. SWINDELL SR. 품 PHYLLIS BE notified 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Yown, State, Zip Code) 2 PHYLLIS REDDITT 3700 GREENSPRING AVE.APT-220-BALTO. MD. 9 20a. METHOD OF DISPOSITION

1 1 Suriel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cametery, cramatory or 20c. LOCATION - City or Town, State must MT. ZION CEMETERY LANSDOWNE, MD. 4 Donation 5 Other (Specify) examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. NORTH AVE. medical 23. PART I. Enter the disesses, or complications that cause the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximata shock, or heart failure. Liet only one cause on each line IMMEDIATE CAUSE (Final Onset end Deeth the disesse or condition resulting in death) . ACUTE NARCOTIC INTOXICATION traumatic event, DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediata cause. Enter UNDERLYING other 1 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE any XX YES 2 \ NO OF DEATH? XX YES 2 NO PHYSICIAN: 2 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) HOSPITAL:
1 | Inpatient 2 | DANOutpatient 3 | DOA OTHER: NO 2 NO ng Home 5 Residence 6 Other (Specify) 4 Nurs 10 28e. DATE OF INJURY
(Month, Dev. Year)
FOUND: 12/11/9 27. MANNER OF DEATH marked, 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO 1 Netural 5 Pending м UNKNOWN 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
FOUND AT HOME 261. LOCATION (Street and Number or Rural Route Number, STREE' BALTIMORE, MARYLAND 3 Suicide 6 Could not be COMPLETED 4 Homicide 29e. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. TO THE HOSPITAL (TO THE FUNERAL C be filed within 72 h MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) end manner as stated. 296. SIGNATURE AND TITLE OF PERTIFIER 29d. DATE SIGNED (Month, Day, Year)
12-12-90 29c. LICENSE NUMBER BE Wight M.D. for OCME 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print) MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 31. DATE FILED (Month, Day, Year, 32. REGISTRAR'S SIGNATURE DEC 14 Davidson-Randall

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| | 4. SOCIA | L S |
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| | 9e. FACI | LITY |
| DIRECTOR | 91 | |
| 5 | RESID | |
| 2 | 10a. STA | TE |
| 5 | Ma | ry |
| 4 | 10e. STR | EET |
| FUNERAL | 91 | 2 |
| 51 | 11. MARI | TAL |
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| FOR STATE REGISTRAR | 1 | STATE OF MAR | | | OF HEALTH AND | MENTAL | HYGIENE REG. NO. | 30 | 34273 |
|---|----------------------------|---|----------------------------|-----------------|--|--------------|-------------------------------|------------------------------|---|
| 1. OECEOENT'S NAME (First, I | Middle, Last) | | <u> </u> | 10/11/2 | 0. 02, | 2. DATE | OF OEATH | YEAR | 3. TIME OF DEATH |
| John Fr | ancis | Seller | s Sr. | | | | ember 14 | | М |
| 4. SOCIAL SECURITY NUMBER | R 5. | 11100 | GE (In yrs. last birthday) | | YEAR IF UNDER 24 HRS. | | OF BIRTH , Day, Year) | 8. BIRTI | HPLACE (State or Foreign try) |
| 218 30 5833 | | M 2 □ F | 55 YRS. | | | | 27/35 | Mar. | vland |
| 9e. FACILITY NAME (If not inst | | 241 (214) | | | OWN OR LOCATION OF D | EATH | | | |
| 912 Sandaly | | ad | | 1 1 | ssex | | В | altimo | re County |
| | 10b. COUNTY | | 10c. CF | TY, TOWN OR | LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | Baltim | ore | Es | sex | | - | | | 1 TYES 2 NO |
| 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | 10 | - | WHAT COUNTRY? |
| 912 Sandaly | | | | | 212 | | | | .S.A. |
| 11. MARITAL STATUS 1 Never Married 2 1 1 3 Widowed 4 Diver | larried | FORCES? 1 1 Y | ES 2 WNO | H : | AS DECENDENT OF HISPA ree, specify Cuben, Mexic YES 2 NO Speci | an, Puerto F | | No — 14. RAC Blac Spec | E — American Indien, ck, White, etc. city: White |
| 15. DECE | DENT'S EDUCAT | TON Translated | 16a. OECEDENT | S USUAL OCC | UPATION | 16b. | KIND OF BUSINE | SS/INOUSTRY | *************************************** |
| Elementary/Secondary (0- | | College (1-4 or 5+) | III. Do NOT | use retired.) | ring most of working | | 01 | 1 0 | |
| 10 | | | Safety | Super | | | Chemica | | iny |
| 7. FATHER'S NAME (First, Mic | | | • | | | | Middle, Maiden Sun | name) | |
| William | | Lers | 1-2-2-2 | | | | Nahrer | | |
| 90. INFORMANT'S NAME (7)/ Margaret Ani | | rs | | | Street and Number or Rural 100d Road B | | nore Mar | yland | |
| on, METHOD OF DISPOSITION COMMENTS OF THE PROPERTY OF THE PRO | 3 🗆 Remove | al from Stata | other place) | | of cemetery, crematory or | | | ION — City or T | |
| Donation 5 Other (| | ore | HOLLY F | | emorial Gar | | Balt | imore (| County, Maryl |
| . 1 | Z Z | 0 | -/ | | zdzinski F | | 1 Homo | D A | |
| Dan | 019 | mary | m | 140 | 7 Old Fact | orn / | wo Ralt | o Md | 21221 |
| 23. PART I. Enter the dis | | nplications that said | | not anter t | he mode of dying, su | ch aa cerd | flec or respiret | ory arreat, | Approximate Interval Between |
| MMEDIATE CAUSE (Fin | | , | | | 2 | | | | Onset and Death |
| disease or condition resulting in death) | . | | holastat | ie le | ey Ca | | | | 14 |
| | | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| Sequentially list condition | ons, b. | DUE TO (OR | AS A CONSEQUENCE | Offi- | | | | | |
| If any, leading to immed cause. Enter UNDERLY! | | DUE TO TON | AS A CONSCOULAGE | Or j. | | | | | j |
| CAUSE (Disease or Injur that initiated events | | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| resulting in death) LAST | | | | | | | | | |
| | | | | | | | | I. | |
| PART II. Other algorificat | t conditions | contributing to dea | th but not resulting | In the unc | lerlying cause given i | n Part I. | 24a, WAS AN AU PERFORME | | AMAILABLE PRIOR TO |
| | | | | | | | 1 🗌 YES 2 🗌 | NO | OF DEATH? |
| | | | | _ | | | | | 1 TES 2 NO |
| | . sernica i | | | | | | | | |
| 25. WAS CASE REFERRED TO EXAMINER? | F | HOSPITAL: | | OTHER | | | | | |
| 1 YES 2 NO | 1 | 28s. DATE OF INJ | | | ng Home Residence | | H (Specify) SCRIBE HOW INJ | IBA OCCIBEO | |
| A | Pending | (Month, Day, Y | | NJURY M | WORK? | 200. OE | SCHIBE NOW INC. | ORI OCCORED | |
| 2 Destates | nvestigation | 28e. PLACE OF IN | JURY — At home, farm | . street, facto | | 281. LOC | CATION (Street and | Number or Rura | l Route Number. |
| | Could not be letermined | building, etc. | (Specify) | .,, | ,, | | or Town, State) | | |
| 9a. CERTIFIER | | | energy and the energy | | | | | | |
| (Check only | | | | | ne, date and place, end d sinion, death occured at ti | | | | e(e) end manner ea stated. |
| 296 SIGNATURE AND TITLE | OF CERTIFIER | 0 | | | 29c. LICENSE N | UMBER | 2 | 9d. DATE SIGNE | EO (Month, Day, Year) |
| m. Turbel, | Stall | phypilia | | | 10-1971 | Y | | 1419 | 1/91 |
| MIKTARL I | PERSON WHO | FSIL M | C 494 | pe, Print) | eden due | Bal | len M | PLILL | 7 |
| | Ybar) | 32. REGISTRAR'S | | | | | | | |
| 31. DATE FILED (Month, Day, | | | doon Randel | _ | | | | | |

ding physician.

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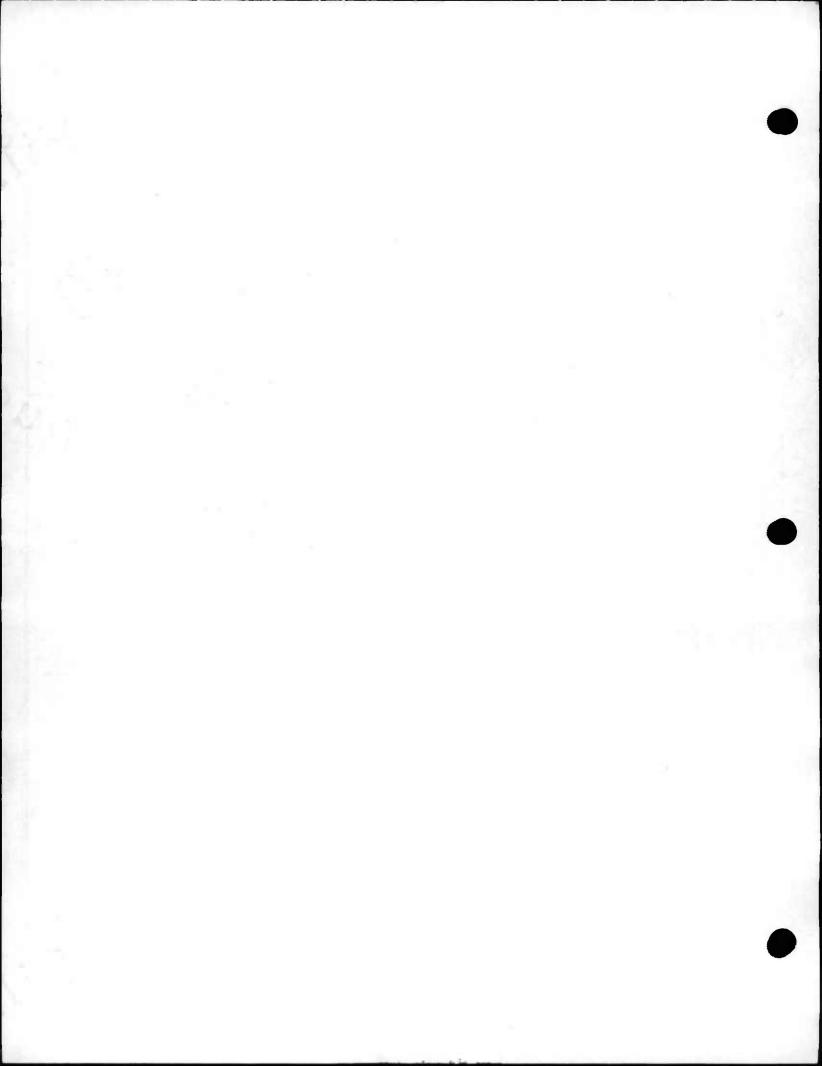
as the burial-transit permit. Pages 1, 2, 3 should

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2... wours after death. Page 6 may be retained by the TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detained within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



| The law requires that the death certificate be executed within 2-rouns after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending phys be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene pi | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other |

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 -CERTIFICATE OF DEATH REG. NO. 3. TIME OF DEATH 1. DECEDENT'S NAME (First, Middle, Last. 2. DATE OF DEATH 4. SOCIAL SECURITY NI 6. AGE (In yrs. lest birthday IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year 8. BIRTHPLACE (State or Foreign DAYS HOURS 07-044 9b. CITY TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR DENT 10d. INSIDE CITY LIMITS? 1 YES 2 NO 10a. STATE RU more BY FUNERAL 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2/230 21230 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARB FORCES? 1 YES 2 1 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify If yea, specify Cubin, Mexican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 3 Widowed 4 Divorced COMPLETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only high Elementary/Secondary (0-12) retir 17. FATHER'S NAME (First, Middle, BE INFORMANT'S NAME (Type/Pri 2 EA 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION 2 Cremation 4 Donation 5 Other (Specify) MARSHA 23. PART I. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart fellure. List only one cause on each line. Onset and Death IMMEDIATE CAUSE (Final disease or condition PNUEMONIA with SEPSIS resulting in death) DUE TO (OR AS A CONSEQUENCE OF): AIZTERIOSCLEROTIC MEART MISEASE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? TIZACT INFECTION ~ URINARY 1 TES 2 NO OF DEATH? DEMENTA 1 ☐ YES 2 ☐ NO ULCERS DECUBITUS 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Planetiant 2 ER/Outpetient 3 DOA OTHER: 1 YES 2 NO ng Home 6 - Rasidence S - Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Matural 6 Pending 1 YES 2 NO 2 Accident 28a. PLACE OF INJURY — At home, farm, street, factory, office building. etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 4 Homicide 29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the b est of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated. 296 SIGNATURE AND TITLE OF CERTIFIES 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE D 23300 12.12.90

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2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PATEL SUDHIR. 31. DATE FILED (Morith, Day, Year) 4 32. REGISTRAR'S SIGNATURE

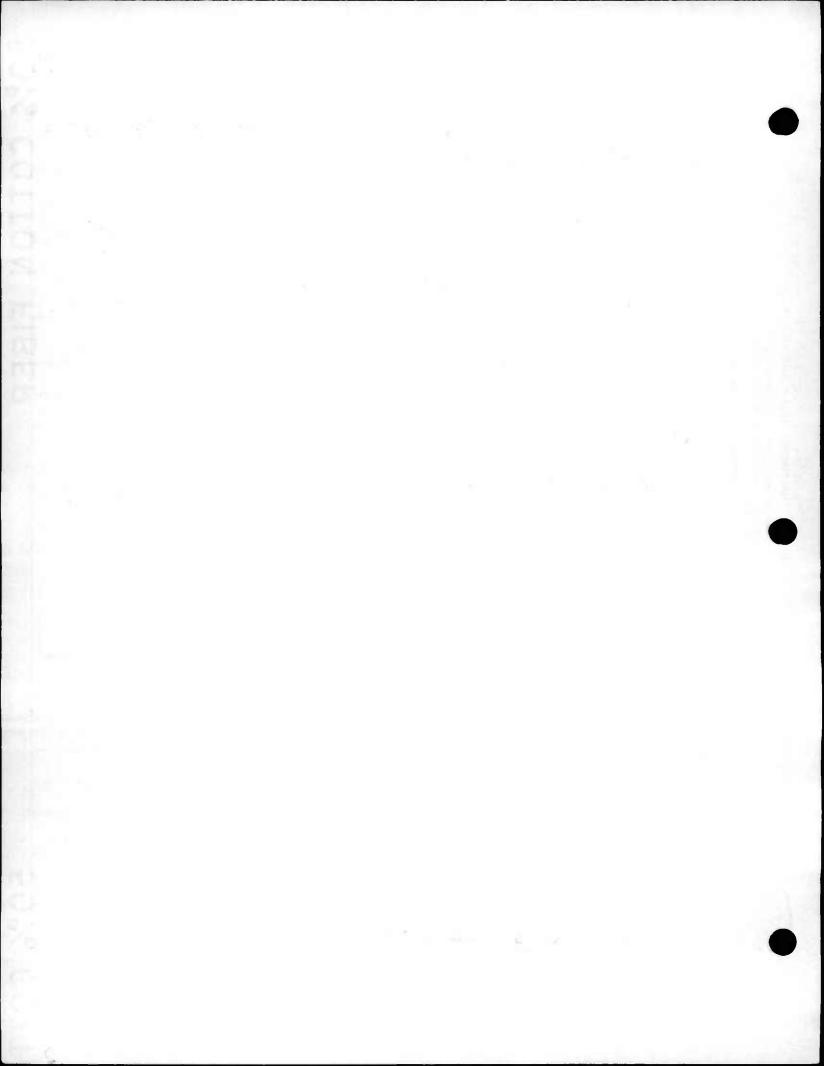
Gulia Davidson-Randa M.

DHMH-16 Rev 1/89

MD, 21215

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miny filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages 1, 2, 3 should

int, the medical examiner must be notified at once.

emation, or removal.

DEC 14 1990

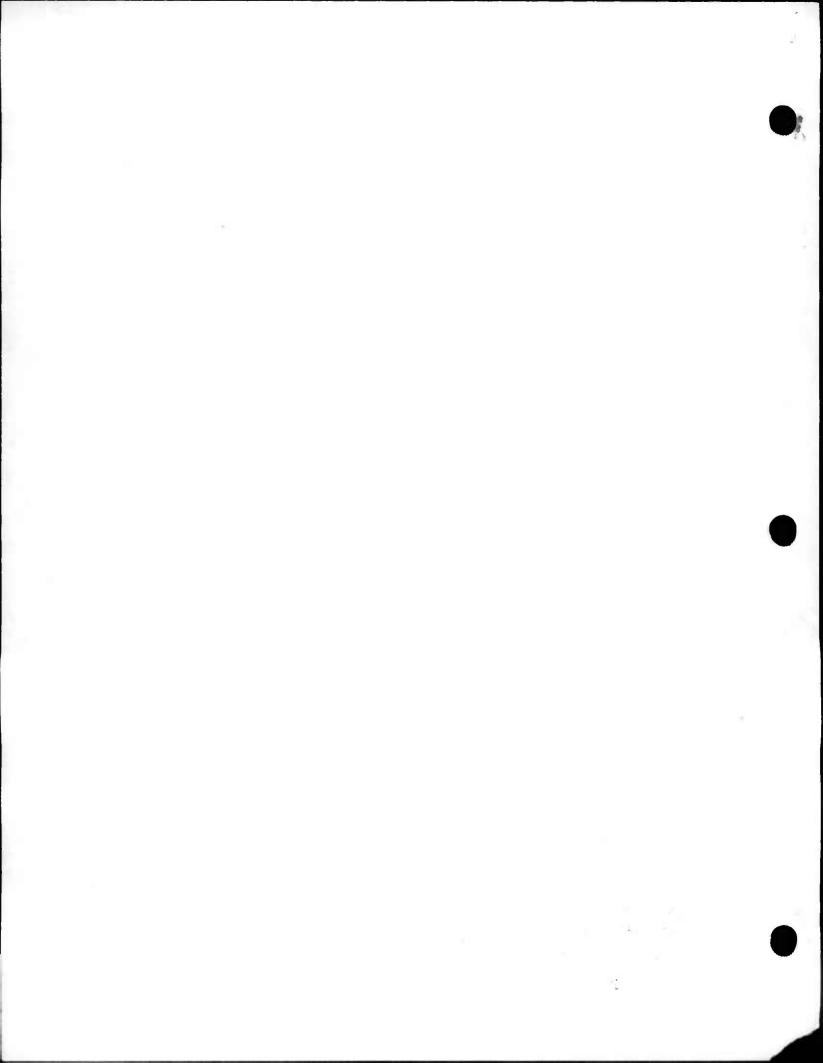
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | IL OR ATTENDING PHYSICIAN: The law | L DIRECTOR; After this certificate has b | 2 hours after death with the State Dept. | I Item 28 Is marked, or Item 23 |
| DIVISION OF VITAL | MTAL OR ATTENDING PHYSICIAN: The law | RAL DIRECTOR; After this certificate has b | 72 hours after death with the State Dept. | : If Item 28 is marked, or Item 23 |
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| DIVISION OF VITAL | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certifician be executed within 2 | TO THE FUNERAL DIRECTOR; After this certificate has been signed by the attending prospering of contracting of | filed within 72 hours after death with the State Dept. | IMPORTANT: If Item 28 Is marked, or Item 23 shows any injury, or other transfile opent, th |

| | FOR 1 - STATE | STATE OF MARYL | AND / DEPART CERTIFIC | | | | ENE | 0 34275 |
|---------------|---|--|--|-------------------------------|---|---|------------------------------------|---|
| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | Tiller. | Ir. | DATE OF | DEATH | REG. 2. DATE OF DEATH MONTH | DAY 2 9 | ~ |
| | 4. SOCIAL SECURITY NUMBER 218-28-6841 | 5. SEX 8. AGE (| | IF UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Yea | 33 | BIRTHPLACE (State or Foreign Country) |
| OR OR | 9a. FACILITY NAME (If not institution, give st | treet and number) en M.P.R.C | enten | BA | TOO M | EATH | 9c. COUNT | Y OF DEATH |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCA | TION | | • | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER | ALAMEd | | | 1. ZIP CODE 2/234 | | 10g. CITIZE | N OF WHAT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, s | CENDENT OF HISPA beelfy Cuban, Mexico S 2 NO Specia | NIC ORIGIN? (Specify an, Puerlo Rican, atc. fy: | Yes or No— 14 | RACE — American Indian, Black, White, atc. Specify: BLACK |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | COTION completed) College (1-4 or 5+) | 16a. DECEDENT'S U (Give kind of wo life. Do NOT use | rk done during m retired.) | ost of working | | BUSINESS/INDUS | - America |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) | 5, | | | | AME (First, Middle, Ma | / | |
| 10 | BROWDE, T. | RAMSOM | 19b. MAILING A 5611 | DDRESS (Street | 4) | Route Number, City or | Town, State, Zip C | ode) |
| | 20a, METHOD OF DISPOSITION Buriel 2 Cremetton 3 Ram Donation 5 Other (Specify) | ovel from State | o. PLACE OF DISPOSITION OF PLACE OF PLA | | metery, cremetory or | | LOCATION - CH | ty or Town, State |
| | 21, SIGNATURE OF FUNERAL SERVICE LIC | tock of | | 22. NAME A | Dunes | 49 6 1 | 1304) | n. Central at |
| | | complicatione that ceuse List only one cause on e | | t enter the m | ode of dying, aud | ch as cerdiac or r | eepiratory erree | intervel Batwaer |
| | IMMEDIATE CAUSE (Final disease or condition recuiting in death) | a. Metasta DUE TO (OR AS | CONSEQUENCE OF | ig Ca | ranom | q | | 2 years |
| HOL | Sequentially list conditione, if any, leading to immediata | b. Urnaru | CONSEQUENCE OF | - Infe | chion. | | | 7days |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated events resulting in death) LAST | c. SUPERIO (OR AS A | CONSEQUENCE OF | Cave | a Synd | Nome. | | 7 days |
| MEDICAL CE | PART II. Other significant condition | a contributing to deeth b | out not resulting in | the underlylr | ng cause given in | PER | S AN AUTOPSY RFORMED? S 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | OTHER: | PLACE OF DEATH (C | | | |
| ву РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 1 | | | | | RED |
| | 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY building, alc. (Spe | / — At home, lerm, att | eet, lactory, offi | CO | 281. LOCATION (St City or Town, S | | Rural Route Number, |
| COMPLETED | 000) | ICIAN: To the best of my know | | | | | | I, cause(a) and mannar as steted. |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIE 30. NAME AND ADDRESS OF PERSON WITH | IGEL MO | | | 29c. LICENSE NU | IMBER | 29d. DATE : | SIGNED (Month, Day, Year) 3 12 90 |

THE CAUSE OF DEATH (ITEM 27) (Type, Print)

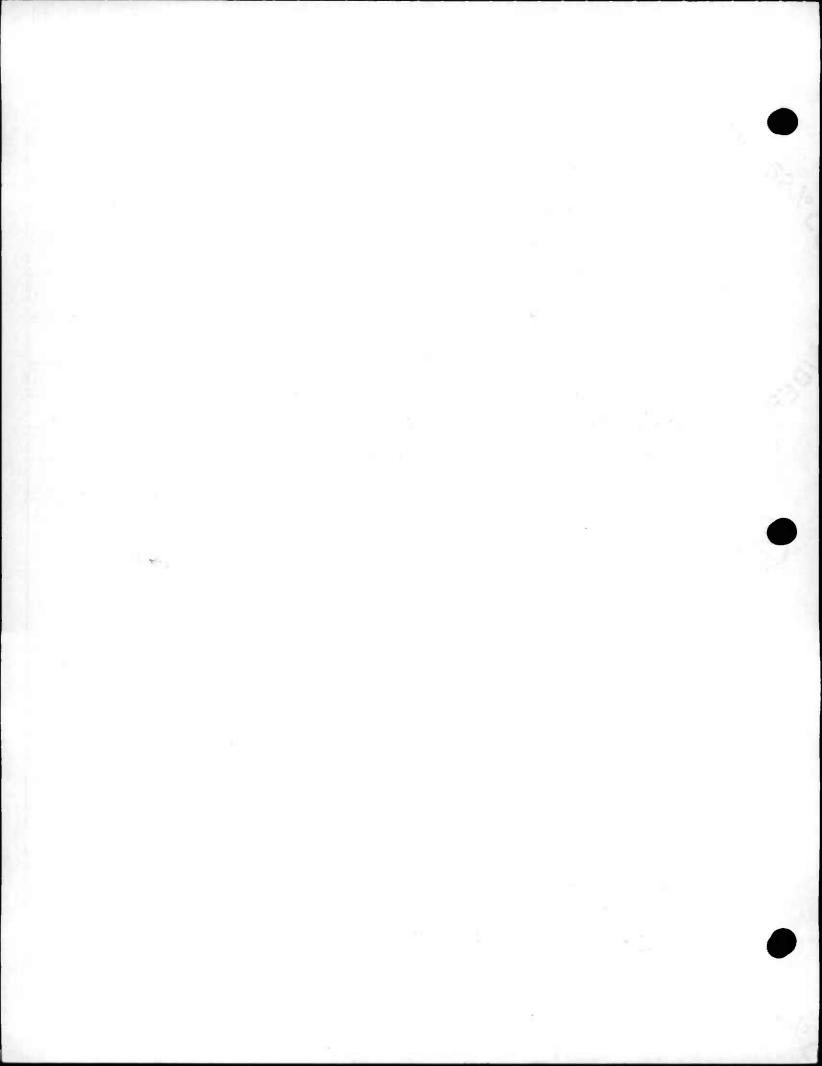
22. 5. GYELL'R St.

Baltimore, MD



ITEMS:23 thru 28f per MF G-671 1/19/91 cm

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| The Information of Deposition of Deposition of Depo | 111 | | 1 | | n A S | | <u>145.50</u> | en Bly | 18. MOTHER'S NA | ME (First, Middle, Ma | niden Surname) | <i>G-L</i> | ectric |
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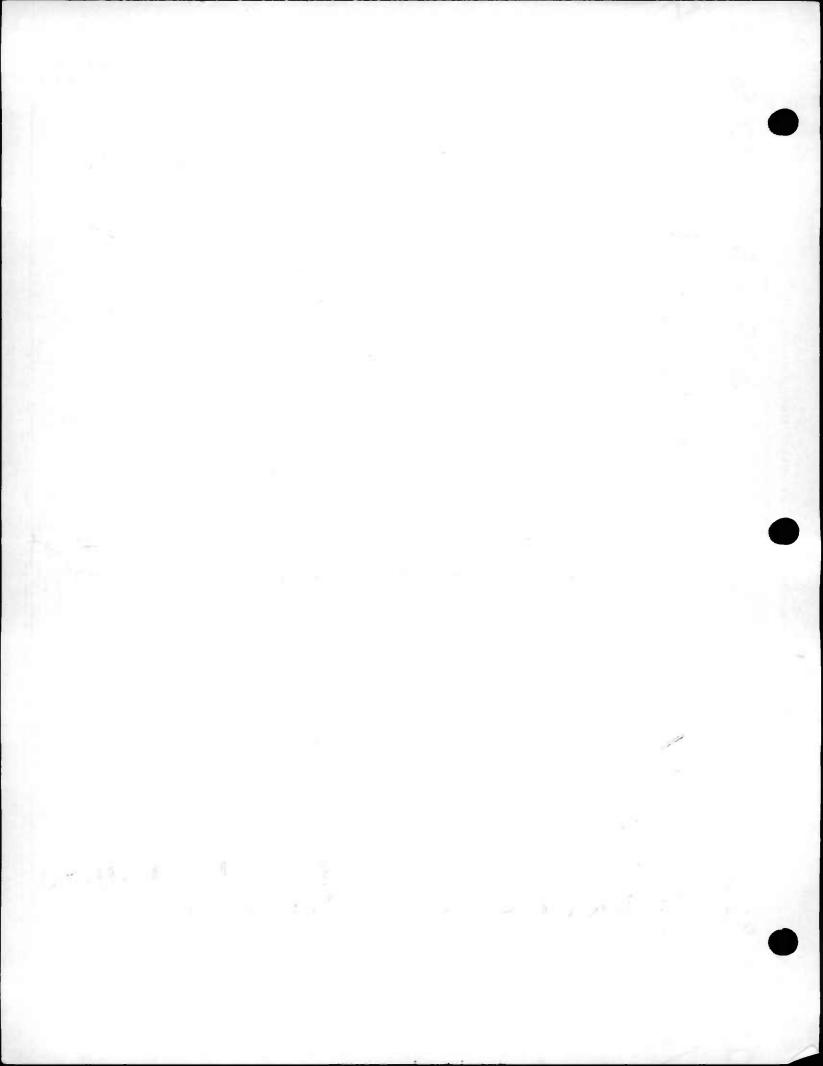


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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The I was not a set certificate be executed within 24 fours after death. Page 6 may be retained by the I | TO THE FUNERAL DIRECTOR: After this certificate has men from the later of the fine within 72 hours after death with the State Deat, or here the solar Moriene prior to burlal, cremation, or removal. | IMPORTANT: If item 28 is merked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at one |
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| | 1 - FOR REGISTRAR | STATE OF MARYLAND / DEPARTM | MENT OF HEALTH AND NEATE OF DEATH | MENTAL HYGIENE REG. NO. | 0 04511 |
|---------------|--|---|---|--|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | O. Tolson | | 2. DATE OF DEATH MONTH DAY 905 | 3. TIME OF DEATH |
| ~ | 4. SOCIAL SECURITY NUMBER 2/4-20-2720 9a. FACILITY NAME (If not institution, give st | 1 M 2 F YRS. MO | UNDER 1 YEAR IF UNDER 24 HRS. WHIS DAYS HOURS MIN. D. CITY, TOWN OR LOCATION OF DE | 7-26-25 B | IRTHPLACE (State or Foreign pyrity) A 17 M (1) OF DEATH |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | em Itve | DA //imore | City | 10d, INSIDE CITY |
| | MANULAND | B. | AlTimore | | 1 Pres 2 No |
| FUNERAL | 924 HARI | em Ave | 101. ZIP CODE 2/2/7 | U. | SAA, |
| ĭ B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES | 13. WAS DECENDENT OF HISPANI If yee, specify Cuben, Mexican 1 YES 2 NO Specify. | , Puerto Ricen, etc.) | RACE — American Indian, Black, White, atc. |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) (Give kind of work life. Do NOT use re | done during most of working | Educatio | w |
| BE CO | 17. EATHER'S NAME (First, Middle, Last) | is tolson | 18. MOTHER'S NAM | AE (First, Middle, Melden Surname) HWNEEL | ee |
| 10 E | 199. INFORMANT'S NAME (Typo/Print) | Harris 924 | PORESS (Street and Number or Rural FI | oute Number, City or Town, Style, Zip Code | 2/2/7 |
| | 20a. MPTHOD OF DISPOSITION 1 | oval from State 20b. PLACE OF DISPOSITION Office place | ON (Name of cometery, crematory or | 20c. LOCATION — City of Port To | or Town, State |
| | 21. HONGTUNE OF FUNERAL SERVICE LIC | I. Russ | 22 HAME AND ADDRESS OF FAC | the Ave. BALL | Home Wall |
| | shock, or haart failure. | complications that caused the death. Do not List only one cause on each line. | enter the mode of dying, such | as cardiac or respiratory arrest, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | DUE TO (OR AS A CONSEQUENCE OF): | Car Dus | Rane | Onset and Death |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A GONGEOUENCE OF) | +ma | | 444 |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| MEDICAL | PART II. Other algolificant condition | s contributing to death but not resulting in t | the underlying cause given in i | Part I. 24s. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 28. PLACE OF DEATH (Che | ck only one) | |
| PHYSICIAN: | 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outpetient 3 DOA 4 28e. DATE OF INJURY (Month, Day, Year) 28b. TIME O INJURY | Nursing Home 6 N Residence | 6 Other (Specify) 28d. DESCRIBE HOW INJURY OCCURE | D |
| B | Netural 6 Pending Investigation 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY — At home, farm, attre- building, etc. (Specify) | M 1 YES 2 NO | 281. LOCATION (Street and Number or Ri City or Town, State) | ural Route Number, |
| COMPLETED | | CIAN: To the best of my knowledge, death occurred a | | | use(s) end manner as stated. |
| BE | 2014 SIGNATURE AND TITLE OF CERTIFIE | | DO 6 | | INED (Month, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE OF BRANCH (ITEM 27) (1) pos. 171 | -MAH RO | em all | |
| | at. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE Julia Davidson-Rondall | 1 | | |



DHMH-16 Rev 1/89

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| | 1. DECEDENT'S NAME (First, Middle, Las | , | TUK | NIC | L A | DEATH | 2. DATE | OF DEATH | | · · · · · · · · · · · · · · · · · · · | TIME OF DEAT |
|---------------|--|--------------------------------|---|-------------------|----------------|---|--------------|----------------------------------|-------------------|---------------------------------------|--|
| | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. last | _ | IF UNDER 1 YEA | R IF UNDER 24 HRS. | 7 DATE | OF BIRTH | | -VI | ACE (State or Foreign |
| | 219165993 | 1 XM 2 🗆 F | 65 | - | ONTHS DAY | | (Mont | h, Day, Year) | | Country) | |
| | 9e. FACILITY NAME (if not institution, give | | 405 | | Pb. CITY, TOW | /N OR LOCATION OF | | 21-2 | 9c. COUNT | | <u>rland</u> |
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| RECTOR | RESIDENCE OF DECEDENT | | | | | | E | | | | |
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| 2 | MD . | | | В | altir | NOTE | | | 10- CITIZ | 1. | T COUNTRY? |
| 5 | 2206 Presbury | Ctwoot | | | | 21216 | | | | | COUNTRY |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARM | IED | 13. WAS | DECENDENT OF HISP | ANIC ORIGIN | 17 (Specify Ya | | U.S. | - American Indian, |
| B | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 [IF YES, GIVE WA | | rmy | | , specify Cuben, Mexi YES 2 STNO Spe | | Ricen, atc.) | | Black, \ Specify: | Black |
| | 15. DECEDENT'S El (Specify only highest gra | | (Gh | e kind of wo | SUAL OCCUP | ATION most of working | 166 | KIND OF BU | ISINESS/INDU | STRY | |
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| COMPL | | | | Olla | ulei | | | | Gove | rnme | nt |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S | | | | | |
| 2 | Joseph Tur | ner | 101 | MAII IBMS A | nnpeer / | Mat eet end Number or Run | ilda | | | Code ¹ | |
| 2 | Lucille Turne | 34 | | | | | | _ | | ,000) | |
| | 20% METHOD OF DISPOSITION | | | | | bury St | | 20c. LG | MD DCATION — C | 2 1 2 | State . |
| | 1 Donellon 5 Other (Specify) | emoval from State | other plac | ce) | | est Vet | | OT | | | s, MD. |
| | 21. SIGNATURE OF FUNERAL SERVICE | | | | 22. NAM | E AND ADDRESS OF | FACILITY | III J | | | |
| | Doutho | 2 Hecto | n #: | 281 | E.I | Philli | ps F | | - | 7 N. | Monroe 21217 |
| CERTIFICATION | Sequentially list conditions, if eny, laeding to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | OR AS A CONSECUTION OR AS A CONSECUTION OR AS A CONSECUTION OF AS | UENCE OF): | C | obn C | erc | (404 | иа | | |
| | PART II. Other eignificant condit | iona contributing to | daath but not ra | suiting in | the underl | ying cause given | in Part I. | 24a. WAS AI | N AUTOPSY | | /ERE AUTOPSY FINDING |
| 4: MEDICAL | | | | | | | | 1 TYES | | 0 | OMPLETION OF CAUSE OF DEATH? YES 2 NO |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HODDITAL | | | | B. PLACE OF DEATH (| Check only o | ne) | | | |
| YSICI | 1 TES 2 NO | HOSPITAL: | ER/Oulpatient 3 | | OTHER: | Home 5 - Residence | e 6 🗆 Oth | er (Specify) | | | |
| ВУ РНУ | 27. MANNER OF DEATH Statutal 5 Pending 2 Accident Investigation | 26s. DATE OF I (Month, Da | | 28b. TIME INJU | RY | WORK? | 28d. DE | SCRIBE HOW | INJURY OCC | JRED | |
| 9 | 3 Suicide 6 Could not 8 | 26e. PLACE OF building, e | INJURY — Al hon ntc. (Specify) | ne, ferm, st | reet, factory, | office | | CATION (Street or Town, State | and Number o | or Rural Roo | rte Number, |
| MPLET | one) — | YSICIAN: To the best of a | | | | | | | | | and manner se stated |
| 8 | 29b. SIGNATURE AND TITLE OF CERTIF | | | | | 29c LICENSE N | | | | | fonth, Day, Year) |
| BE | Mon. 1 | +05)11 | ion . | | | 007 | 758 | | ▶ /: | 2-9 | -97 |
| 2 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUS | E OF DEATH (ITEM | 27) (Type, I | Print) | 1001 | | | ,,, | | 10 |
| | MARVIN T. 1 31. DATE FILED (Month, Day, Year) | E L DUA | 4V, MO | 2 40 | 391 | St. Por | 1 PC | oce, | Bol | tople | 110 2126 |
| | DEC 1 4 199 | Julia Da | Nagara Man | - | | | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
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| CERTIFICATE OF DEATH | REG. NO. |

| | 1. DECEDENT'S NAME (Fin | rst, Middle, Last) | | | ATE OF D | | 2. DATE O | REG. NO. | YI | EAR | . TIME OF DEATH |
|--|--|---|--|--|--|---|--|---|--|---|--|
| | 4. SOCIAL SECURITY NUM | MBER | Joseph Vru | | F UNDER 1 YEAR | IF UNDER 24 HRS. | /2 | 12 F BIRTH | 90 | | 3:00 P. ACE (State or Foreign |
| | 220-12-790 | | 1 € M 2 □ F | 65 YRS. M | ONTHS DAYS H | OURS MIN. | (Month, | 26 2 th | | Country) | Md. |
| TOR | 73/4 Alvah | Avenu | | 9 | b. CITY, TOWN OR | dalk | ATH | 9 | Bal | of DEA | |
| DIRECTOR | Md. | 10b. COUNT | altimore | 10c. CITY, 1 | Dundalk | | | | | - 1 | IOd. INSIDE CITY LIMITS? |
| FUNERAL | 73/4 Alvah | | ve. | | | 2/222 | | 10 | - | S.A | AT COUNTRY? |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 3 Wildowed 4 Dis | | 12. WAS DECEDENT EV FORCES? 1 X IF YES, GIVE WAR O | YES 2 NO | If yes, speci | IDENT OF HISPAN Ify Cuben, Mexice NO Specify | n, Puerto Ri | | No- 14. | RACE - Black, Specify: | - American Indian, White, atc. |
| TED | | ECEDENT'S ED | UCATION | 16a, DECEDENT'S US | BUAL OCCUPATION is done during most options.) | of working | 16b. | KIND OF BUSINE | SS/INDUS | TRY | |
| COMPLET | Elementary/Secondary | (0-12) | College (1-4 or 5+) | Relief 1 | 4. | | 9 | eneral | Moto | no (| Сопр. |
| To | 17. FATHER'S NAME (First, | | blic Sno | | 1 | 16. MOTHER'S NA Helen | | | name) | | |
| TO BE | Joseph Vra | (Type/Print) | 111 | 19b. MAILING AI | DDRESS (Street and | Number or Rural F | Route Numbe | or, City or Town, S | itate, Zip Co | de) | |
| must be | 20e. METHOD OF DISPOSE 1 Description 2 Crement 4 Donation 6 Other | tion 3 🗆 Red | moval from State | 20b. PLACE OF DISPOSIT | | tery, cremetory or | | 20c. LOCAT | | | |
| examiner r | 21. SIGNATURE OF FUNER | | ICENSEE A L | le . | | | | | | | ern Ave. |
| e medical | shock, or IMMEDIATE CAUSE (F | heert failure | . List only one cause i | on each line. | enter the mode | of dying, suci | h sa cardi | ac or respiret | ory errest | | Approximete Interval Betw |
| event, the | shock, or | ditions, nedieta. YING | s | AS A CONSEQUENCE OF): | enter the mode | of dying, suci | h sa cardi | ac or respiret | ory errest | | Approximete Interval Betw |
| hows any injury, or other traumatic event, the MEDICAL CERTIFICATION | shock, or IMMEDIATE CAUSE (F disease or condition resulting in death) Sequentially list cond if any, leading to imm cause. Enter UNDERL CAUSE (Disease or in that initiated events resulting in death) LA PART II. Other significations are consistent to the condition of the condi | ditions, nedleta YING plury | b | AS A CONSEQUENCE OF): | tis 1 | e of dying, such | Cour | ac or respiret | TOPSY 107 | 24b. 1 | Approximete Interval Betw Onset and D WERE AUTOPSY FIND MAILABLE PRIOR TO |
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31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

Jula Davidson-Randall

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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the darm printed to executed within 24 mours after do | file | be filed within 72 hours after death with the State Dept. of Health and Mean Hydron and Devial. cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or while traumatic event, the medical ex |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH 12 0120 # I.STF

4. SOCIAL SECURITY NUMBER WELLER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 11/15/10 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTNPLACE (State or Foreign MONTHS DAYS HOURS 215-09-7679 80 1 M 2 X F VRS Maryland Se. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATN UNION MEMORIAL HOSPITAL BALTIMORE CITY 10c. CITY, TOWN OR LOCATION 10e STATE 10b COUNTY 10d. INSIDE CITY Maryland Baltimore Pikesville 1 YES 2 NO 10e. STREET AND NUMBER 101 ZIP CODE 10g. CITIZEN OF WNAT COUNTRY? 101 Sherwood Ave. 21208 United States 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No---14. RACE — American Indien, Bleck, White, etc. If yee, specify Cuben, Mexican, Puerto Ricen, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Merried Specify: White 3√ Widowed 4 □ Divorced 18e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION pecify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe Elemantary/Secondery (0-12) College (1-4 or 5+) College Bethlehem Shipping Secretary 17. FATHER'S NAME (First, Middle, Last) 16. MOTNER'S NAME (First, Middle, Maiden Surname) George Edwin Brooks Ada May Sorden Wagner 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 816 Olmstead Road Pikesville, MD Mrs. Mildred L. Marshall 21208 20e. METHOD OF DISPOSITION

TEXTURE 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State Baltimore, MD Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Home K WHY -amae 8728 Liberty Road Randallstown, MD 21133 23. PART I Enter the diseases, or complications that care the death. Do not antar the mode of dying, such as cardiac or reapiratory arrest, Approximate shock, or heart fallure. List only one cause Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): mal boure Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, laading to immadiata cause. Enter UNDERLYING Winam Nuch CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events reaulting in death) LAST PART II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 - YES 2 - NO OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATN (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO 1 Department 2 ER/Outpatient 3 DOA me 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 26b. TIME OF 28c. INJURY AT WORK? 28d, DESCRIBE NOW INJURY OCCURED INJURY 1 Natural
2 Accident 5 Pending М 1 YES 2 NO Investigation 28a. PLACE OF INJURY — At homa, ferm, street, factory, office building, etc. (Specify) 3 Sulcide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Nomicide 29a. CERTIFIER 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end manner se stated. 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Day, Year) P Cull and PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print 130 MI

TO BE COMPLETED BY FUNERAL DIRECTOR

| uires that the demonstrature be executed within 22-mours after death, Page 6 may be retained by the hospital or attending physician. | mer to burial, cremation, or removal. | rked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|
| ertificate b | Mg physics representation | other tra |
| 3 | Matel Hydron | Jury, or |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the filed within 72 hours after death with the State Dept, of Health and It | IMPORTANT: If Item 28 is marked, or Item 23 shows any in |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | | | | | | C | 0 | 34281 | |
|--|---------------------------------------|--|---|--|-------------------------------|--------------|---------------------|--|--|
| FOR STATE REGISTRAR | STATE OF MARY | YLAND / DEPARTI CERTIFIC | MENT OF | HEALTH AND MORE DEATH | WENTAL HYGIEN | IE | | 1 100 0 1 | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | 4 1 | | | 2. DATE OF DEATH | | 3. | TIME OF DEATH | |
| | RANCIS V | WHITE | | | | - | YEAR | SILTS M | |
| 4. SOCIAL SECURITY NUMBER | | | IF UNDER 1 YEAR | | 7. DATE OF BIRTH | | . BIRTHPLA | ACE (State or Foreign | |
| 217-05-1775 | 1 M 2 F | 77 YRS. | MONTHS DAYS | | (Month, Day, Year) 2/15/13 | | Mary Mary | yland | |
| 80. FACILITY NAME (If not institution, give s B3 H0 more Co. Co. | eneral Hospits | 8 | Bb. CITY, TOWN | And Allstow | | 1 | Y OF DEATH | e Co. | |
| 10e. STATE 10b. COUNT | Y | 10c. CITY, | TOWN OR LOC | CATION | 1000 | | | d. INSIDE CITY | |
| Maryland Balt | timore | Ran | ndallst | town | | | | LIMITS? | |
| 10e. STREET AND NUMBER | / | | | 10f. ZIP CODE | | 10g. CITIZE | | T COUNTRY? | |
| 3412 Carriage Hil | 11 Circle A | Apt 103 | | 21133 | | U.S | | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YE | R IN U.S. ARMED | 13. WAS D | DECENDENT OF HISPANI | IC ORIGIN? (Specify Yes | | | American Indian, hite, etc. | |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | | If yes, | specify Cuben, Mexicen. /ES 2 X NO Specify: | , Puerto Ricen, etc.) | | Const. | Nhite | |
| 15. DECEDENT'S EDU (Specify only highest grade | iCATION e completed) | 16e. DECEDENT'S US (Give kind of work | rk done durina i | CTION most of working | 16b. KIND OF BUS | SINESS/INDUS | STRY | | |
| Elementary/Secondery (0-12) | College (1-4 or 5+) | ille. Do NOT use n | retired.) | | | | | | |
| | 2 Years | Termina | Terminal Manager Pre | | | | reston Trucking Co. | | |
| 17. FATHER'S NAME (First, Middle, Last) | 2 | | | | ME (First, Middle, Maiden | Sumame) | | | |
| Leolin F. White | ≥, Sr. | | | | ie Cox | | | | |
| 18e. INFORMANT'S NAME (Type/Print) | | | | et and Number or Rural Ro | | | | 21133 | |
| Mrs. Sybil White | | | | ge Hill Ci | rcle Apt | 103 R | anda] | llstown,MD | |
| 20a METHOD OF DISPOSITION 12 Method 2 Cremetion 3 Rame 4 Donetion 5 Other (Specify) | noval from Stata | other place) Wico | Wicomico Memorial Park 20c. LOCATION — City or Town, State Salsburth Maryland | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | 22. NAME | AND ADDRESS OF FACI | HLITY | 0 | | | |
| Dohn 2 | < Ayrus | 4 | | B Liberty Ding Byers D | | | | | |
| 23. PART I. Enter the diseases, or o | complications that cau | sed the death. Do not | t antar the n | IIK DYCLS node of dying, such | as cardiac or respi | retney arras | rs, I | Approximate | |
| ahock, pr heart failure. IMMEDIATE CAUSE (Finsi disesse or condition resulting in death) | List Dniy Dna causa on | s A CONSEQUENCE OF): | | | | 1800 y = 0 | | Intarval Batwean Onaet and Death | |
| Sequentially liat conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Diaease or injury that initiated events resulting in desth) LAST | c | S A CONSEQUENCE OF): | PAGO | menia | | | | | |
| PART II. Other significant conditions | e contributing to death | had not reculting in | · · · · · · · · · · · · · · · · · · · | - trong las f | | | | | |
| The vina significant | a continuouna to assert | Dut hot resummy in a | the underry | ng causa given in r | Part I. 24e. WAS AN PERFOR | RMED? | COM | RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? | |
| | | | | | _ | | 1 [| YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | |
| EXAMINER? | HOSPITAL: | | THER: | PLACE OF DEATH (Chec. | | | | | |
| 1 TES 2 NO | 1 Inpatient 2 ER/Ou | | | ome 5 - Reeldence 6 | Other (Specify) | | | | |

27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending investigation 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At homa, ferm, street, fectory, office building, atc. (Specify) 3 Suicide 261. LDCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29e. CERTIFIER (Check only one)

1 _ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dete end piece, end due to the ceuse(e) end menner ee stated.

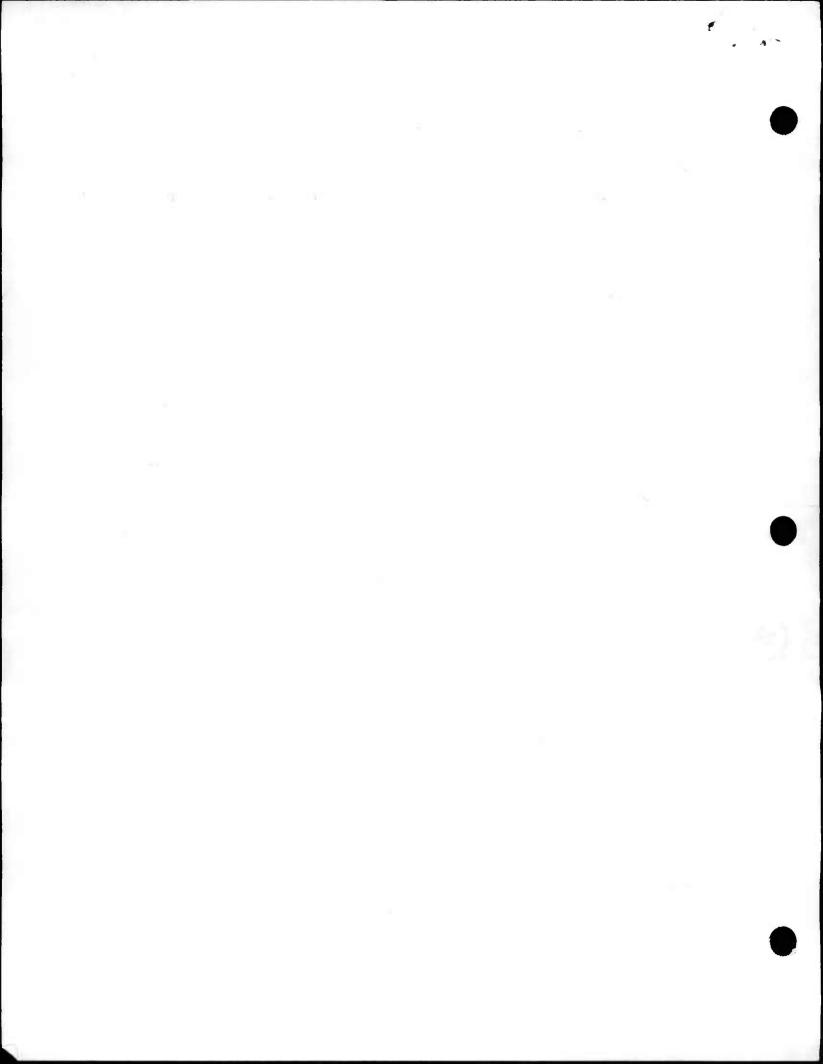
2 __ MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

28c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 30. NAME AND ADDRÉSS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

1

丁. 32. REGISTRAR'S SIGNATURE

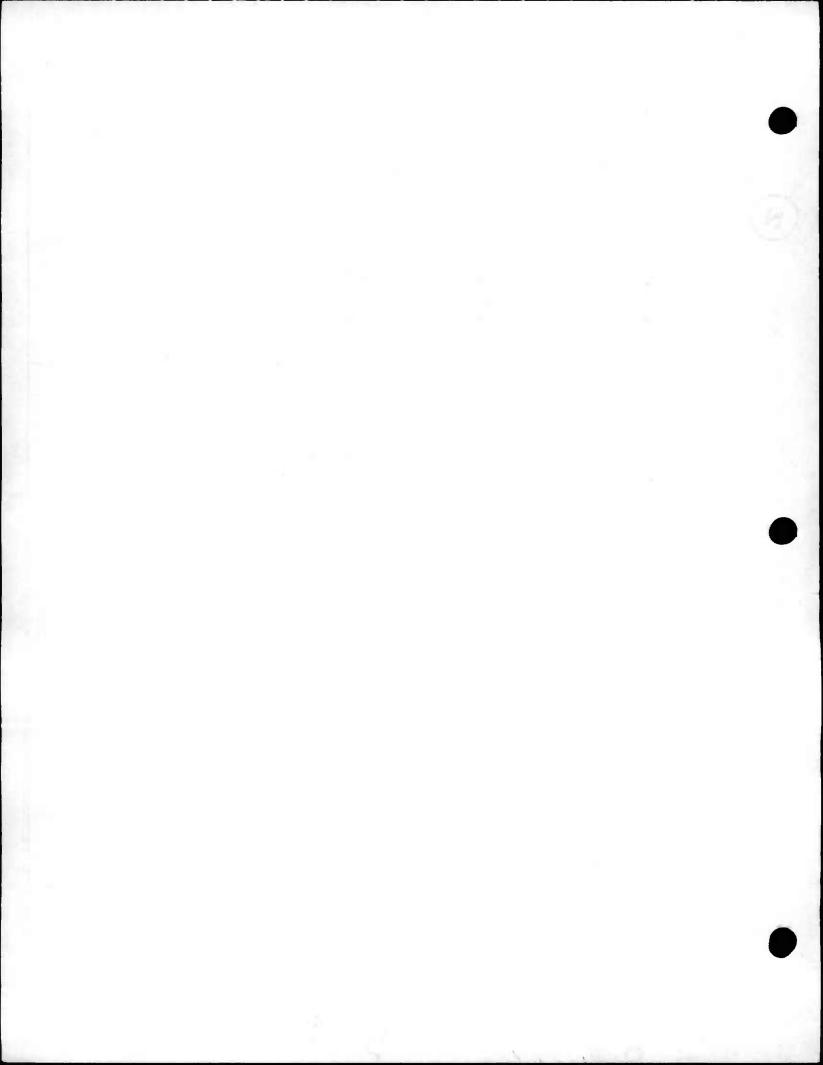




| BALTIMORE, MARYLAND 21203-3146 | retained by the hospital or attending physician. | 5 should be detached for use as the burial-transit permit. \sim DeY \sim FH G-670 \sim 12/18/90 | notified at once. |
|--|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within cx. dours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit, be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. \Box \Box \Box \Box \Box \Box \Box \Box \Box \Box | IMPORTANT If Nem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| DIVISION OF VITAL RE | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requ | TO THE FUNERAL DIRECTOR: After this certificate has been be filed within 72 hours after death with the State Dept. of ! | IMPORTANT: If Item 28 is marked, or Item 23 show |

31. DATE FILEO (MONTO)
DEC

| | G-670 12/18/90 Cm FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | | | | IE . | 34202 |
|------------------------|--|--|-------------------------------|--------------------------------|--------------------------------|--|-------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) Frank | C.ull | | Wimmer | DEATH | 2. DATE OF DEATH MONTH 12-5-90 | AY YE | 3. TIME OF DEATH 6:52PM |
| | | | yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) April 6 1 | 0 | MRTHPLACE (State or Foreign Country) Kentucky |
| OR | 9a. FACILITY NAME (If not institution, give stree 2814 Miles Avenue | | 17 | | or Location of Di altimore | EATH | 9c. COUNTY | |
| DIRECTOR | nesidence of decedent 10a. STATE 10b. COUNTY Maryland | | | TY, TOWN OR LOCA | TION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 2814 Miles Avenue | e | | | 1. ZIP CODE | | | OF WHAT COUNTRY? |
| ВУ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 3/10 | If yes, s | | NIC ORIGIN? (Specify Yearn, Puerto Rican, atc.) y: | a or No— 14. | RACE — American Indian, Black, White, atc. Specify: White |
| COMPLETED | 15. OECEDENT'S EDUCAT (Specify only highest grade co. Elamentary/Secondery (0-12) | TION impleted) College (1-4 or 5 +) | (Give kind of life. Do NOT | , | ost of working | 16b. KIND OF BU | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | Liectro | ATTICS TE | | ME (First, Middle, Malder | Sumame) | nry |
| BE | Cullen F. Wimmer 190. INFORMANT'S NAME (Type/Print) | | 19b. MAILIN | G ADDRESS (Street | Clara | P. Puryea Route Number, City or Tow | r vn, State, Zip Coo | (0) |
| 5 | Cullen F. Wimmer | | -640 | 6-Gainsb | orough L | Dr., Ralei | ah. N. | C. 27612 |
| | 20a. METHOD OF DISPOSITION 1 Deurlai 2 Cremation 3 Remov 4 Donasion 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICEN | from State | Dulane | y Valley 22. NAME A Lemr | nd address of fa non–Mitcl | I Gardens | feld | |
| | 23. PART I. Enter the disesses, or corshock, or heart failure. List IMMEDIATE CAUSE (Finel disesse or condition resulting in death) | | INJURY | | oda of dying, suc | th as cerdiec or resp | oiratory errest, | Approximete Interval Batwe Onset and Dag |
| CERTIFICATION | Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in desth) LAST | DUE TO (OR AS A | | | | | | |
| PHYSICIAN: MEDICAL CER | PART II. Other significant conditions CIRRHOSIS OF THE | | ut not resulting | g in the underlyle | ng cause given in | | RMED? | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX |
| AN: M | 25. WAS CASE REFERRED TO MEDICAL | | | 28. 1 | PLACE OF OEATH (C | heck only one) | | MONTH I III |
| SIC | | HOSPITAL: 1 Inpatlant 2 ER/Outp | etlent 3 DOA | OTHER: 4 Nursing Ho | me XXXesidence | 6 Other (Specify) | | |
| BY PHY | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a, DATE OF INJURY (Month, Day, Year) | | NJURY W | JURY AT ORK? YES 2 NO | 28d. OEŞCRIBE HOW SUBJECT | | ON HEAD |
| | 3 Suicide 6 Could not be 4 Momicide determined | 28e. PLACE OF INJURY building, etc. (Spec | | , street, fectory, off | Ce | 281. LOCATION (Street City or Town, State 2900 BIK | MILES | Rural Route Number, AVENUE |
| COMPLETED | one) | AN: To the best of my know | | | | | | auso(a) and menner as stated |
| B | 296. SIGNATURE AND TITLE OF CENTIFIER | | | | 29c. LICENSE NU OCME | MBER | | GNED (Month, Day, Year) 2-6-90 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO ANN M. DIXON, MD | COMPLETED CAUSE OF OE | | | reet,Bal | ltimore,MD | 21201 | - - |



1. DECEOENT'S NAME (First, Middle, Last)

FOR STATE REGISTRAR

31. DATE FILED (Month, Day DEC 1 DFC

4

3. TIME OF DEATH

Ma

10d. INSIDE CITY LIMITS? 1 X YES 2 NO

- American Indian.

2121

Approximate

COMPLETION OF CAUSE

OF DEATH? 1 TES 2 NO

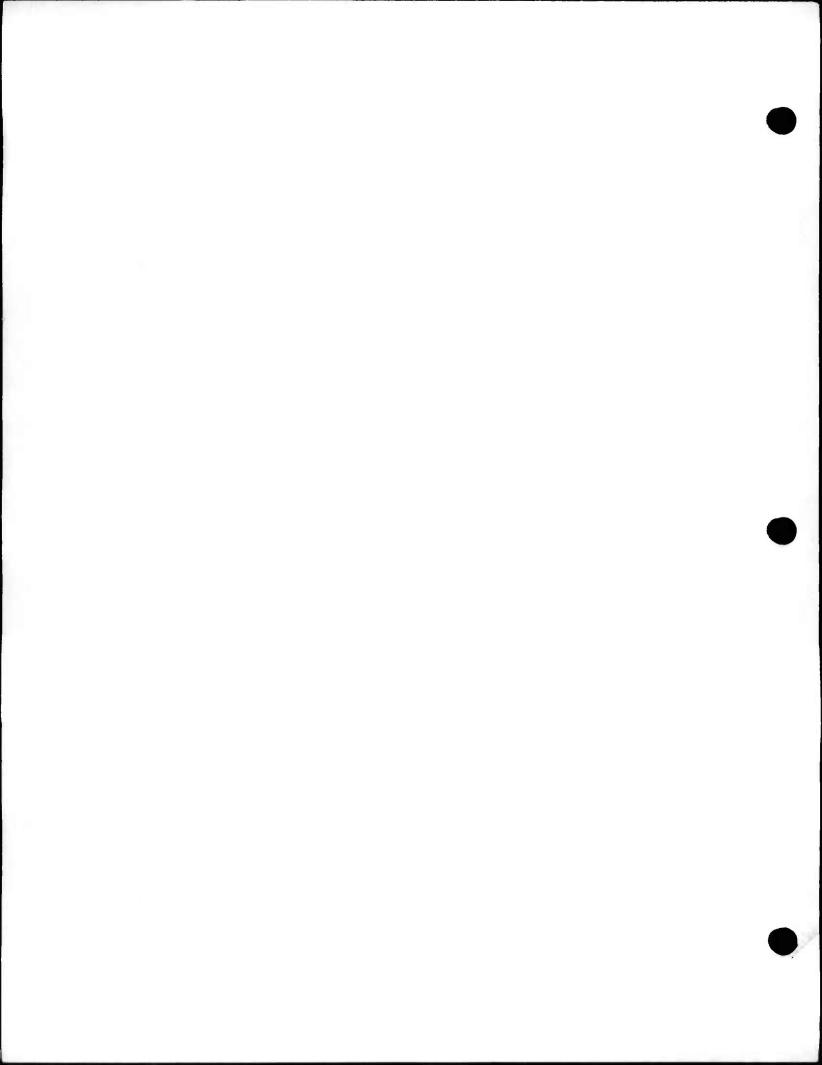
Interval Between **Onset and Death**

BEG NO

DIVISION OF VITAL RECORDS, P.O. BOX 13146.

2. DATE OF DEATH DAY 8. BIRTHPLACE (State or Foreign SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birth) 7. DATE OF BIRTH (Month, Day, Year) IF UNDER 1 YEAR IF UNDER 24 HRS. DAYS The burial-transit permit. Pages 1, 2, 3 should 90. FACILITY NAME (If not Institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH FUNERAL DIRECTOR RESIDENCE EDENT 10c. CITY, TOWN OR LOCATION 70 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 2/2/ affending physician. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 ☐ NO IF YES, GIVE WAR OR OATES 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerlo Ri 1 TYES 2 NO Specify: B 3 Widowed 4 Divorced COMPLETED 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only high conderv (0-12) College (1-4 or 5+) 124 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname page 5 should be det notified at BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Nu Zio Codel 2 2 20s, METHOO OF DISPOSITION
1 Burlel 2 Cremation 3 Reg 20b. PLACE OF DISPOSITION 20c LOCATION - City or Town, State must funeral director, Donetion 5 - Other (Specify) examiner 21, SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME completely filled in by the rial, cremation, or removal. medical complications that caused the daeth. Do not enter the mode of dying, 23. PART I. Enter tha diseeses, or such as cardiec or reepiretory arrest, ahock, or heart failure. List only one ceuse on each IMMEDIATE CAUSE (Final 23 shows any injury, or other traumatic event, the disease or condition reculting in death) HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DUE TO (OR AS A CONSE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and corr within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, PHYSICIAN: MEDICAL CERTIFICATION Sequantielly list conditions, If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events OUE TO (OR AS A CONSEQUENCE OF) resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDE TO 1 YES 2 .NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) marked, or Item HOSPITAL: 1 YES 2 NO lient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO В 2 Accident TO THE HOSPITAL OR ATTENDING TO THE FUNERAL DIRECTOR: Afte be filed within 72 hours after deal IMPORTANT: If Item 28 Is m 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Sulcide COMPLETED 8 Could not be 4 🗌 Homicide determined 1 🖵 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(e) and manner as stated. 2 MEDICAL EXAMINER: Q estigation, in my opinion, death occured at the time, date end place, end due to the ceuse(e) end menner 29b. SIGNATURE AND TITLE OF CERTIFIE 29d. DATE SIGNED (Month, Day, Year) BE 9 30. NAME AND AGORESS OF PERSON WHO COM ncure

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

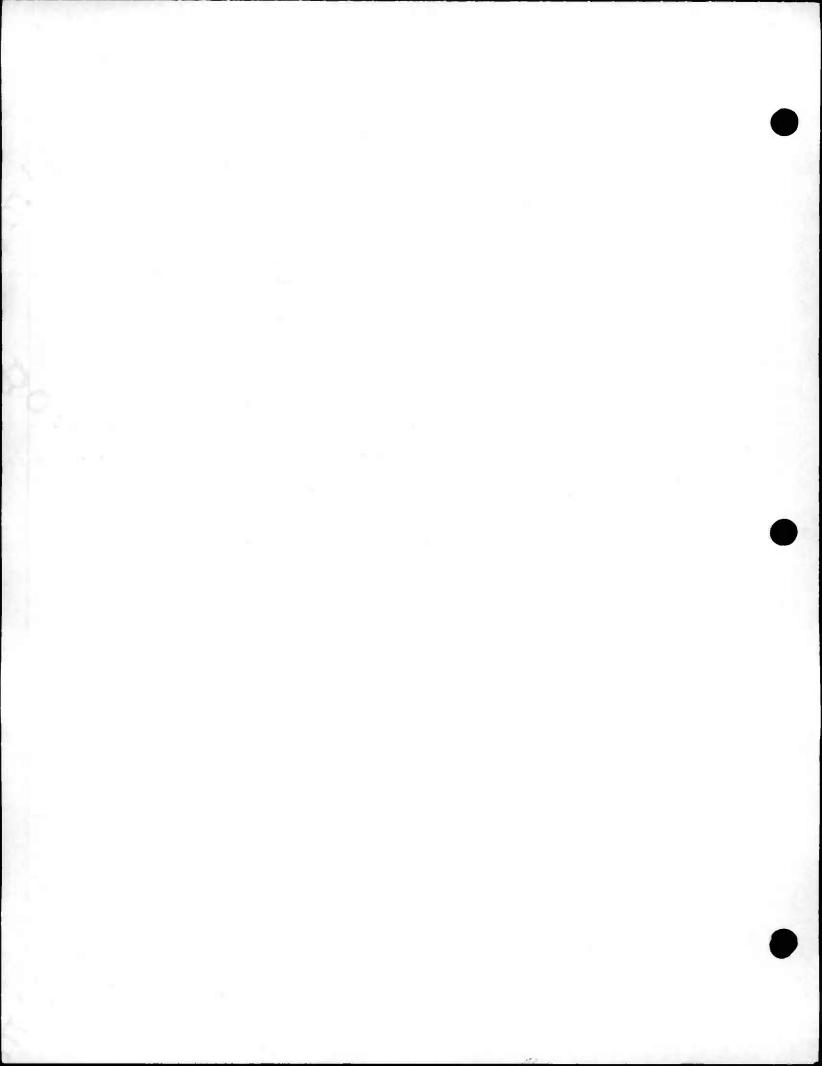


| BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL OR ATTENDING PHYSLOW THE WAS THAT THE death certificate be executed within 2. Tours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this company that the principle of the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | e medical examiner must be notified at once. |
|---|---|--|
| DIVISION OF WITH RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSI ON THE WASHINGTON TO THE ACCOUNT OF THE FUNERAL DIRECTOR: After this compared to by the attending physician and completely filled in by the formal within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | | ICATE OF DEAT | | REG. NO. | | | |
|--|---|--|--|---|--|---|---|---|
| 1. DECEDENT'S NAME (First, Middle, Last) |) | | | 2. D. | ATE OF DEATH | YEA | 3. TIME OF | DEATH |
| Fra | ink | Witku | ıs, Jr. | " | 12-11-90 | | | 5PM |
| 4. SOCIAL SECURITY NUMBER 215-34-5257 | 5. SEX 6. AGI | E (In yrs. last birthday) 55 YRS. | IF UNDER 1 YEAR IF UNDER | 24 HRS. 7. D/ | ATE OF BIRTH | a B | PA | |
| 9a, FACILITY NAME (If not institution, give | | J 1113. | 9b. CITY, TOWN OR LOCATI | | 110 " 2 7 1 1 | 9c. COUNTY O | | |
| 2122 Broening Hi | | | Baltimor | | | SC. COOKITY | J. DEATH | |
| 10a. STATE 10b. COUN | | 10c. CITY | y, town or location Joppei | | | | 10d. INSID | S? |
| 100. STREET AND NUMBER 921 Joppa Fa | rn keac | | 10f. ZIP COD | .085 | | 10g. CITIZEN | OF WHAT COUN | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EYER FORCES? 1 YE IF YES, GIVE WAR OR | S 2 NO | 13. WAS DECENDENT (If yes, specify Cubi 1 YES 2 MO | n, Mexican, Pua | IIGIN? (Specify Year into Rican, atc.) | or No— 14. | RACE — America Black, White, ato Specify: W. C. | ite |
| 15, DECEDENT'S ED (Specify only highest grad Elamentary/Secondary (0-12) | DUCATION de completed) College (1-4 or 5+) | 18a. DECEDENT'S (Give kind of w life. Do NOT us | USUAL OCCUPATION work done during most of working retired.) | ng | 16b. KIND OF BUS | INESS/INDUST | RY | |
| 12th | | Uti | lity Train | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOT | | irst, Middle, Maiden S | | | |
| Frank Wit | kus Sr. | | ADDRESS (Street and Numbe | | ohine | | | |
| | 1 | | | | | | | |
| MArciaret Wit | | | LUODD&F&XIII | | | | or Town, Stata | |
| 1 S Burial 2 Cremation 3 Res | moval from State | other place) | Hill Cemet | | | - | re Mc | |
| 21. SIGNATURE OF FUNERAL SERVICE L | JCENSEE | 1.1 | 22. NAME AND ADDRE | SS OF FACILITY | 1 | | A. Fr. Jilla. | |
| Connelles | Funeral | Home | / Connell | yFuner | rakHome | 300MA | ceAve | . 2122 |
| immediate cause (Finsi disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | b | clerotic of saconsequence of saconsequen | न्: | ar dise | ease | | | |
| | | | | | | | | |
| resulting in death) LAST | d | | | | | _ | | |
| PART II. Other significant condition | d |) but not resulting | in the underlying cause | given in Part | 1. 24a, WAS AN PERFOR | MED? | COMPLETI | PRIOR TO ON OF CAUSE |
| | d | n but not resulting | In the underlying cause | given in Part | PERFOR | MED? | AWILABLE | PRIOR TO ON OF CAUSE ? |
| | d | n but not resulting | in the underlying cause | given in Part | PERFOR | MED? | AWAILABLE COMPLETI OF DEATH | PRIOR TO ON OF CAUSE ? |
| PART II. Other significant conditions to the significant conditions of the significant condition | d | n but not resulting | 28. PLACE OF | given in Part | PERFOR | MED? | AMAILABLE COMPLETE OF DEATH XIX YES | PRIOR TO ON OF CAUSE ? |
| PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 \(\text{NO} \) NO | done contributing to death HOSPITAL: 1 Inputtent 2 ERVO | outpatient 3 DOA | 28. PLACE OF OTHER: | DEATH (Check or | PERFOR XYES 2 nily one) Xether (Specify) | MED? | AMAILABLE COMPLETI OF DEATH XXX YES | PRIOR TO ON OF CAUSE ? |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 NO 27. MANNER OF DEATH | ons contributing to death | Dutpatient 3 DOA | 28. PLACE OF OTHER: 4 Nursing Home 5 FAE OF 28c. INJURY WORK? | DEATH (Check or Residence XXX | PERFOR | MED? | AMAILABLE COMPLETI OF DEATH XXX YES | PRIOR TO ON OF CAUSE ? |
| PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 VES 2 \(\text{NO} \) 27. MANNER OF DEATH | HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR 10 Date of the state of the | butpatient 3 DOA | 26. PLACE OF OTHER: 4 Nursing Home 5 F AE OF 26c. INJURY AT WORK? M 15C. YES 2 | DEATH (Check or testdence XXX) 28d | PERFOR XYES 2 nily one) Xether (Specify) | MED? | AMAILABLE COMPLETI OF DEATH XXX YES k place | PRIOR TO ON OF CAUSE ? 2 \(\text{NO}\) |
| PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? LEXAMINER? LEXAMINER OF DEATH Meturel 5 Pending Investigation of beached a determined 29a. CERTIFIER (Check only 1 CERTIFYING PH) | HOSPITAL: 1 Inpatient 2 ER/O 28a. DATE OF INJUR 10 Date of the state of the | Dutpatient 3 DOA RY 28b. TiM IN. JRY — At home, farm, specify) | 28. PLACE OF OTHER: 4 Nursing Home 5 F AE OF | DEATH (Check or testdence 28d 28d 28d 28d. | PERFOR MX YES 2 Minhy one) Xether (Specify) I. DESCRIBE HOW II City or Town, State) The cause(a) and man | WOT: | AMAILABLE COMPLETI OF DEATH XXX YES K place ED Bural Route Numb | PRIOR TO ON OF CAUSE? |
| PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 2 Accident 5 Pending Investigation 9 Pending Investiga | HOSPITAL: 1 Inpettent 2 ERVO 28a. DATE OF INJUG (Month, Dey, Yea 28a. PLACE OF INJUG building, etc. (S | Dutpatient 3 DOA RY 28b. TiM IN. JRY — At home, farm, specify) nowledge, death occurration and/or investigation | 26. PLACE OF OTHER: 4 Nursing Home 5 F AE OF | DEATH (Check or testdence 28d 28d 28d 28d. | PERFOR MX YES 2 When (Specify) I. DESCRIBE HOW II City or Fown, State) The cause(a) and man, data and place, an | WOY. NJURY OCCUR and Number or H more as stated. and dus to the c. | AMAILABLE COMPLETI OF DEATH XXX YES K place ED Bural Route Numb | PRIOR TO ON OF CAUSE? 2 NO NO NO NO NO NO NO NO NO NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANER OF DEATH X Netural 5 Pending Investigation 3 Suicide 6 Could not b detarmined 29a. CERTIFIER (Check only one) MEDICAL EXAMINER? | HOSPITAL: 1 Inpettent 2 ERVO 28a. DATE OF INJUR (Month. Dey. Yea 28a. PLACE OF INJUR building, etc. (\$ YSICIAN: To the best of my kr INER: On the basis of axamine WHO COMPLETED CAUSE OF | Dutpatient 3 DOA RY 28b. TiM IN. JRY — At home, farm, specify) nowledge, death occurration and/or investigation | 26. PLACE OF OTHER: 4 Nursing Home 5 F AE OF | DEATH (Check or leaddence 28d 28d 28d 28d 28d 28d 28d 28d 28d 28d | PERFOR MX YES 2 When (Specify) I. DESCRIBE HOW II City or Fown, State) The cause(a) and man, data and placa, and | WOY NJURY OCCUR There is a stated. Index due to the country of | AMAILABLE COMPLETION DEATH XXX YES R place Rural Route Numb GNED (Month, De 2-12-90) | PRIOR TO ON OF CAUSE? 2 NO NO NO NO NO NO NO NO NO NO |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Law Journal after death. Page 6 maybe mander by the hospital or an extension provided the control of the control | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, purple, ground of detached for une at the burnal by fine attending the first and Mental Hydiene Drift to burlat cremation, or removal. | IMPORTANT: If I lem 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the find within 72 hours after death with the State Dent of Health and | IMPORTANT: If Item 28 is marked, or Item 23 shows any In |

permit. Pages 1, 2, 3 should

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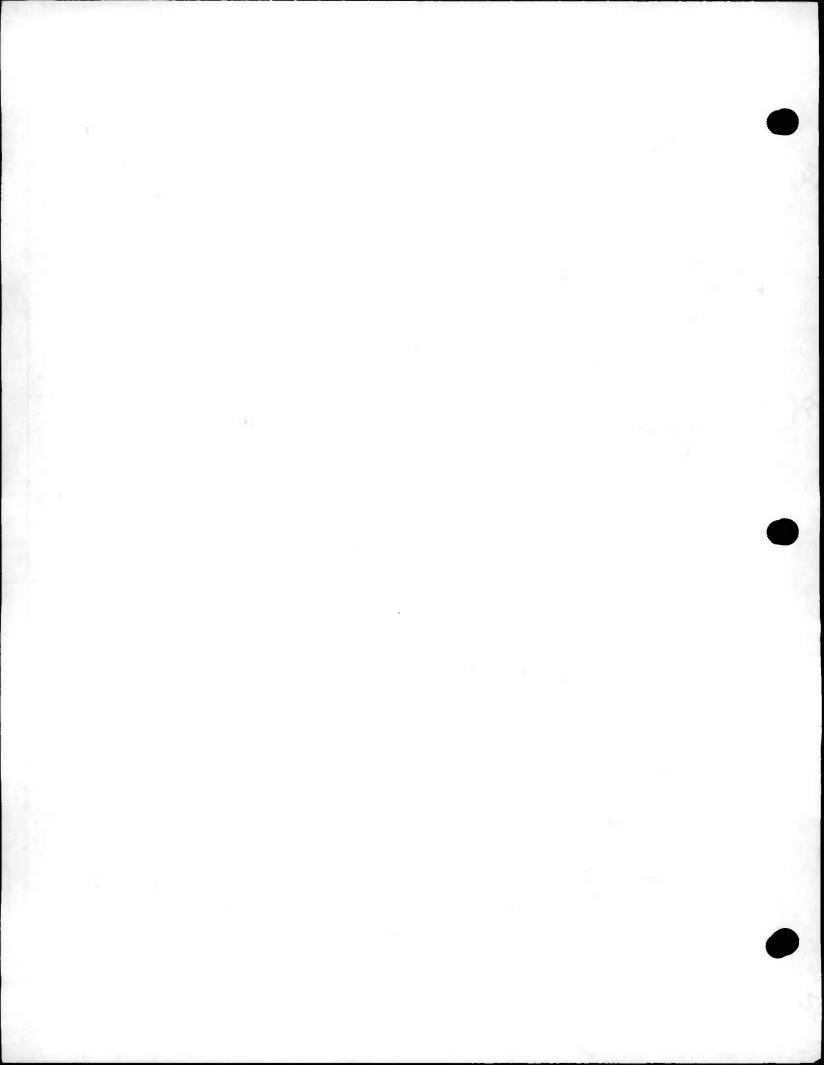
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATN 3. TIME OF DEATH 1990 YEAR Clash 11:15 Myrtle Waters PM 8, AGE (In yrs. last birthday) 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR 7. DATE OF BIRTH B. BIRTNPLACE (State or Foreign IF UNDER 24 HRS. 57-07-2436 10 M2 XF 11-3-1909 81 YRS. ambridge, md 9a. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATN 9b. CITY, TOWN OR LOCATION OF DEATN Baltimore DIRECTOR Essex Road Baltimore RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10e. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? Baltimore 1 YES 2 NO Md Baltimore FUNERAL 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 3321 Essex Road 21207 S U A 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—
If yes, specify Cuban, Mexican, Puerto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2
IF YES, GIVE WAR OR DATES 1 Never Married 2 Married Specify BY 3 Widowed 4 Divorced **Black** COMPLETED 15. DECEDENT'S EDUCATION 16s. DECEDENT'S USUAL OCCUPATION 16h, KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) Collega (1-4 or 5+) Teacher ucation 4yrs 17. FATNER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname Clarence Bennett Edith Clash BE 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1145 Hopson Mill Dr Naperville, IL Esaw W. Waters 60540 20s. METHOD OF DISPOSITION
1 Disposition 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cometery, cremetory or other place Wall Cemetery 20c. LOCATION — City or Town, State Cambridge, Md 21, SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Anthony Ward 314 cove st. Grisfield: M March F/h West a 4300 Wabash Avenue / 23. PART I. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cerdiec or respiretory erreat, shock, or heart failure. List only one cause on each line. **Approximate** Interval Between **Onset and Deeth** IMMEDIATE CAUSE (Final disease or condition Enderviseda disease theroscleration resulting in death) CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PHYSICIAN: MEDICAL Pailure MAIL ARL E PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO pertension 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER: 1 VES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 - Hosidence 6 - Other (Specify) 4 Nurs 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. OESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation 1 YES 2 NO BY Accident 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be COMPLETED 4 Nomicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and menner as stated 2 MEDICAL EXAMINER: On the basis of axamination snd/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as ateted. AND TITLE OF CERTIFIER D 2898 29d. DATE SIGNED (Month, Day, Year) BE Mens 2 RSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

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M.D.

32. REGISTRAR'S SIGNATURE

LOCH RAVEN BLUD



| ne hospital or attending physicial | detached for use as the burial-tri | once. |
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| ecuted within 2 Juns after death. Page 6 may be retained by the | nd completely filled in by the funeral director, page 5 should be det burial, cremation, or removal. | stic event, the medical examiner must be notified at on |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 - Jurs after death. Page 6 may be retained by the hospital or attending physic | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tin be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

MARYLAND 21203-3146

BALTIMORE.

P.O. BOX 13146,

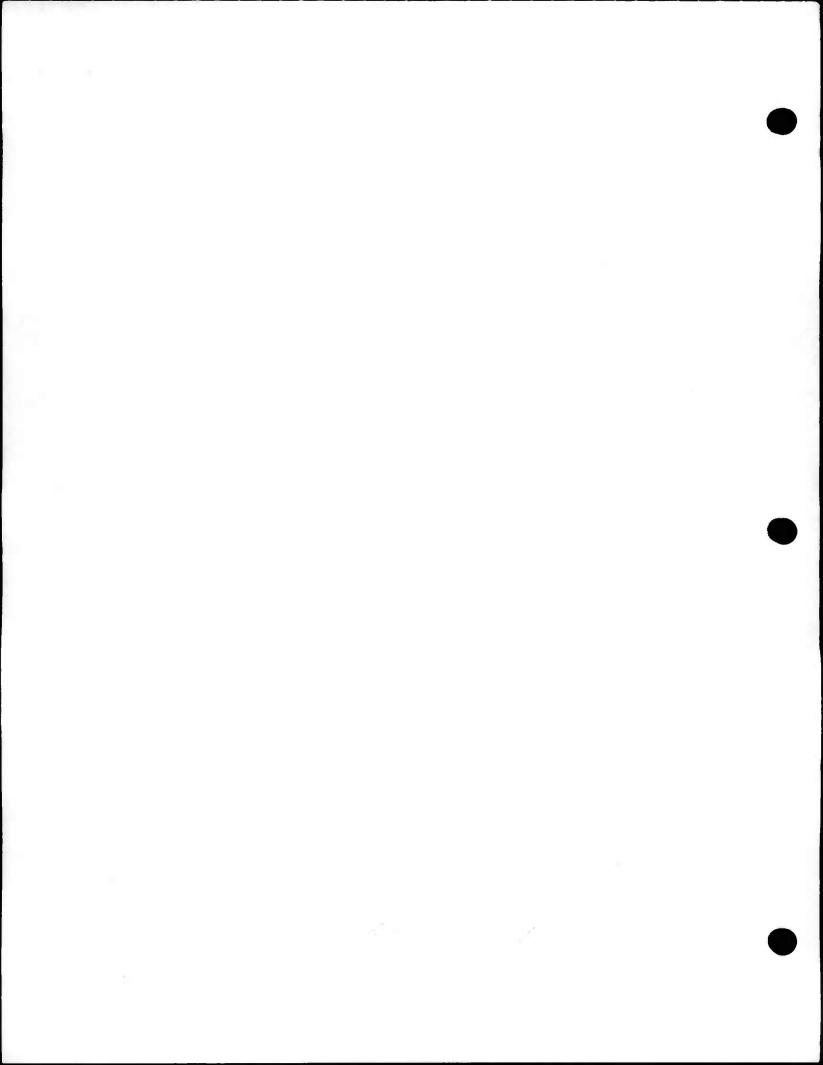
DIVISION OF VITAL RECORDS.

223

12-12-97

REG. NO. 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH YEAR JAMES R. WILLIS, SR. 12 90 7:00 P. 5. SEX 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 8. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 8. BIRTHPLACE (State or Foreign DAYS 1 🔯 M 2 🗌 F YRS. 230-03-1115 68 01 03 21 VIRGINIA 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR 3005 KESWICK ROAD BALTIMORE RESIDENCE OF DECEDENT 10a, STATE 10c. CITY, TOWN OR LOCATION 10d. INSIGE CITY LIMITS? MARYLAND 1 YES 2 | NO BALTIMORE FUNERAL 10e, STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 3005 KESWICK ROAD 21211 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year or No-14. RACE — American Indian, Black, White, etc. If yes, specify Cuban, Maxican, Puarto R

1 ☐ YES 2 ☐ NO Specify: FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Married 2 X Married Specify: BY 3 Wildowed 4 Divorced WHITE WW COMPLETED 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working 18b. KINO OF BUSINESS/INDUSTRY (Specify only highest grade co Elementary/Secondary (0-12) College (1-4 or 5 +) 12TH FLOORING CONTRACTOR 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maider Surname) POSEY LESTER WILLIS ROXIE ELIZABETH NICHOLS BE 19b. MAILING AOORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. INFORMANT'S NAME (Type/Print) 5 24014 DISNEY EDWARD WILLIS 3614 BEAR ROAD S.E., ROANOKE, VA. 20a. METHOO OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State W☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from State
 Donation 5 ☐ Other (Specify) CEDARLAWN BURIAL PARK ROANOKE, VA. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY A. ALAN SEITZ, JR. FUNERAL HOME lech 3818 ROLAND AVENUE, BALTIMORE, MD. 21211 23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, auch ee cardiec or respiretory erreat, ahock, or heart failure. List only one cause on each line. Interval Between **Onset and Death** IMMEDIATE CAUSE (Final BSWD disease or condition_ reaulting in death) DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequantially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): thet initieted evants reaulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AMAII ARLE PRIOR TO (so Lan mous a COMPLETION OF CAUSE OF DEATH? 1 TYES 2 TNO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF OEATH (Check only one) OTHER: 1 TYES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 28s. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. OEŞCRIBE HOW INJURY OCCURED 1 Natural 1 YES 2 NO BY 2 Accident 26s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide COMPLETED 6 Could not be 4 Homicide determined 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and dua to the ceuse(s) and manner as stated. (Check only one) MEDICAL EXAMINER: On the besis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 2 29b. SIGNATURE AND 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE 017072 Po 121 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Baltimore, Maryland 21215 3640 Fords 22. REGISTRAR'S SIGNATURE



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires tractine dearly certificate be executed within 22 mounts after death. Page 6 may be retained by the intending physician.

TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| 20 | FOR STATE REGISTRAR | STATE OF MA | RYLAND / DEPAR CERTIF | TMENT OF | | MENTAL HYGIEN | | | |
|-------------------------------|--|---|---|---|---|--|---------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) (Marian) | Marion | С. | YEAGER | | 2. DATE OF DEATH DATE OF DAT | | 3. TIME OF DEATH 90 8:19 P M | |
| OR | 4. SOCIAL SECURITY NUMBER 214-20-4114 | 1 M 2 TF | AGE (In yrs. last birthday) 64 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 NRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4-20-19 | | BIRTHPLACE (State or Foreign Country) Varyland | |
| | 9a. FACILITY NAME (If not institution, give s Franklin Squa: RESIDENCE OF DECEDENT | | tal | F-0.1 | or Location of DE | ATH | Balti | of DEATH More County | |
| DIREC | 10a. STATE 10b. COUNTY | altimore | | y, town on Local | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| COMPLETED BY FUNERAL DIRECTOR | 8810 Fearne | | | | 21234 10 | | | U.S.A. | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 _ IF YES, GIVE WAR | YES 2 NO | If you, a | | IIC ORIGIN? (Specify Yearn, Puerto Ricen, atc.) | n or No 14. | RACE — American Indian, Black, White, etc. Specify: White | |
| | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 12th | CATION completed) College (1-4 or 5+) | (Give kind of life. Do NOT u | usual occupat work done during m se retired.) | ON ost of working | 16b. KIND OF BU | | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | Beer | e var,y | 18. MOTHER'S NA | NAME (First, Middle, Malden Surname) | | | |
| BE C | Lester Merri | ter Merritt Effie Cunningham | | | | | | | |
| 10 | Mr. Alfred P. | Yeager | 881 | 0 Fear | ne Ave. | Route Number, City or Tow Balto | Md. 2 | 21234 | |
| li | 20a METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | oval from Stata | other place) | SITION (Name of a | metery, crematory or | | | or Town, State | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIN | | | | | DAT CO. | | | |
| | Hartley. | Willer | <u>-</u> | 757 | 7 Harfo | ord Rd. I | Balto. | , Md. 21234 | |
| | 23. PART i. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ilna. IMMEDIATE CAUSE (Final disease or condition a. Cerebellar Hemorrhage | | | | | | | | |
| NO | DUE TO (OR AS A CONSEQUENCE OF): Sequentially flat conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | |
| CERTIFICATION | if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | | | |): | | | | |
| CERT | reaulting in death) LAST | d | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other significant condition | a contributing to d | aath but not resulting | in the undarlyi | ng cause given in | Part i. 24a. WAS AF PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS MAILLABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? Y 1 YES 2 NO | HOSPITAL: | ER/Outpatiant 3 🗆 DOA | OTHER: | PLACE OF DEATH (Ch | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF IN (Month, Day) | IJURY 28b. TII | ME OF 28c. II | ma 5 Residence JURY AT ORK? YES 2 NO | 2ad. DE\$CRIBE HOW | INJURY OCCUR | RED | |
| TED BY | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF building, et | INJURY — At home, farm, c. (Specify) | street, factory, off | ce | 28t. LOCATION (Street City or Town, State | and Number or | Rural Route Number, | |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, daeth occurred at the time, data and placa, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the beat of examination and/or investigation, in my opinion, daeth occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | |
| TO BE | 296. SIGNATURE AND TITLE OF CERTIFIE Clava Q. /2 | | . M. A. | | 29c. LICENSE NUI | MBER | 29d. DATE S | 12/12/90 | |
| - | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clara Bozievich, MD 9000 Franklin Square Drive 21237 | | | | | | | | |
| | DEC 14 1990 4 | 32 REGISTRAR | S SIGNATURE | | | | | | |

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filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, on, or removal. urs after death. Page 6 may be retained by the hospital or attending physician. notified at pe other traumatic event, the medical examiner must cremation, or and completely fi burial, crematio executed within signed by the attending physician and Health and Mental Hygiene prior to buri OR ATTENDING PHYSICIAN: The law requires that the death certificate be 23 shows any injury, or DIRECTOR: After this certificate has been shours after death with the State Dept. of Hiem 28 is marked, or item 23 short TO THE FUNERAL DIRECT
De filed within 72 hours at
IMPORTANT: If Item 2 HOSPITAL THE 223

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEN HEINCLA CHARLES OF DEATH REG. NO. Herman 2. DATE QU DEATH 3. TIME OF DEATN YEAR 325 P 11 7. OATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY 5. SE) IPUNDER 1 YEAR 6. BIRTHPLACE (State or Foreign IF UNDER 24 HRS. DAYS 329 8 05 -0 9e. FACILITY NAME (If not institution, g 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR OWARD Howard HOSP JOSEPHOL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MD DlumBIA TOW ARD 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g, CITIZEN OF WHAT COUNTRY? 819 21044 SiA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Mexican, Pt 1 TES 2 NO Specify: 1 Never Merried 2 Merried Specify: В 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade Elementery/Secondery (0-12) College (1-4 or 5+) UNK LINK SELF-EMPIOYED ARMER 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Surname) 18US+ BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Bural Boute Number City or Town, Sta Zip Code 2 6 COLUMBIA MO 20a, METHOD OF DISPOSITION
1 ☑ Suriel 2 ☐ Cremetion 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
SLACK FUNCTOR ATME M00535 ELLICOTT CITY 21043 amplications that caused the death. Do not enter the mode of dying, such se cerdiec or respiretory erreet, List only one cause on each line. ITI. Enter the diseases, or a Approximate shock, or heart Interval Between Onset end Daath IMMEDIATE CAUSE (Final hlumonia disease or condition resulting in daeth) DUE TO (OR AS A CONSEQUENCE OF) 0 con cer. una PHYSICIAN: MEDICAL CERTIFICATION Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in deeth) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 YES 2 NO 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify) 28a. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 26c. INJURY AT WORK? 28d. DEŞCRIBE NOW INJURY OCCURED 1 Natural 1 YES 2 NO В 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, Stata) 3 Sulcide COMPLETED Could not be 4 Homicide 1 CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(e) end menner ee atated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER BE 29d. DATE SIGNED (Month. Nellin 0 0 WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print) 30. NAME AND ADDRESS OF PERSON - M 055

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32, REGISTRAR'S SIGNATURE

31. DATE FILED (Month, Day,

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ages 1, 2, 3 should

| ing physicial | the burishtra | | |
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| tal or attend | for use as | | |
| y the hospit | be detached | | at once. |
| be retained t | be 5 should | | e notified |
| age 6 may | director, pag | | er must b |
| fter death. F | the funeral | loval. | al examin |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 mounts after death. Page 6 may be retained by the hospital or attending play | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for this as the burnal-tran | be filed within 72 hours after death with the State Dept. of Health and Merdal Hyglene pnor to bunal, cremation, or removal. | IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| cecuted within | and complete | bunal, crem | atic event |
| rtificate be e | g physician | iene pnor to | ther traum |
| the death ce | the attendin | Mental Hyg | injury, or o |
| equires that | en signed by | of Health and | hows any |
| N: The law r | icate has be | State Dept. | Item 23 s |
| G PHYSICIAL | er this certif | ith with the | narked, or |
| R ATTENDIN | RECTOR: Aft | urs after dea | n 28 is n |
| HOSPITAL 0 | -UNERAL DI | within 72 ho | TANT: If Ite |
| TO THE | TO THE | be filed \ | IMPORT |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTA CERTIFIC | | | MENTAL HYGIEN | E 9 | 0 34289 |
|-----------------|--|---|--|--------------------|--------------------------------|---|-------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | t) | | | | 2. DATE OF DEATH MONTH D | AY YE | 3. TIME OF DEATH |
| | BERNARD | JOSEPH | | ALVE | Y | | 5,19 | |
| | 4. SOCIAL SECURITY NUMBER 215-18-0578 | | | UNDER 1 YEAR | IF UNDER 24 HRS, HOURS MIN. | 7. DATE OF BIRTH 1 (10/1/26 / 1) | A | BIRTHPLACE (State or Foreign Country) |
| | 9a. FACILITY NAME (If not institution, give | street and number) | 91 | . CITY, TOWN C | R LOCATION OF DE | ATH | 9c. COUNTY | OF DEATH |
| DIRECTOR | Physicians M | lemorial Hos | | | lata | | Cha | rles |
| RE | 10a. STATE 10b. COUN | ITY | | OWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| ٥ | Maryland Cha | rles | La | Plata | | _ | | 1 TES 2 ANO |
| FUNERAL | Ripley Road, | Route 2,Box | 2141 A | 100 | 20646 | 5 | 1 * | J.S.A. |
| 5 | 11. MARITAL STATUS 1 Never Married 2 X Married | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.SARMED | | | IIC ORIGIN? (Specify Ya n, Puarto Rican, atc.) | n or No- 14. | RACE — American Indien, Black, White, atc. |
| 8 A | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | | | 2 NO Specify | | | Specify: White |
| | 15. DECEDENT'S ED | | 16a. DECEDENT'S US | UAL OCCUPATION | DN . | 16b. KIND OF BU | SINESS/INDUS | |
| | (Specify only highest gra Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of work life. Do NOT use n | | | | 1.0.S. | |
| 7 | 12 | | Fire fi | ghter | - Retir | ed U.S. | Sovern | nent |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) Harry Josep | h Alvey | | | 18. MOTHER'S NA | ME (First, Middle, Maider | | ve Jones |
| H H | 19a. INFORMANT'S NAME (Type/Print) | II AIVEy | 405 MAII NIG 14 | | | | | |
| 2 | | A1 17'C | Rt. 2. | Box 2 | 141 A | Route Number, City or Tow La Plata | vn, State, Zlp Co 1 . Marv | land 20646 |
| | Dorothy May 20a. METHOD OF DISPOSITION | 20b | PLACE OF DISPOSITI | | | | | or Town, State |
| | 1 Burial 2 Cremation 3 Ra 4 Donation 5 Other (Specify) | emoval from State | other place) rinity N | | | 7.7. | | ,Maryland |
| ı | 21. SIGNATURE OF FUNERAL SERVICE | LIGHTRINE / | 1 | 22. NAME A | O ADDRESS OF FA | CILITY | | |
| | 1 2 C | co kolo) | h | Ar | ehart F | uneral H | lome,I | nc. 20646 |
| 7 | 23. PART I. Enter the diseases, o | r complications that caused | the death. Do not | antar the mo | da of dying, suc | h as cardiac or reap | Iretory arrest | Approximata |
| | ahock, or haart fallun | e. List only one cause on a | ach ilna. | | | | | intarvai Batwaan Onset and Daath |
| - 1 | disease or condition resulting in death) | . Cercoro | Var uch | 027 S | ander | 2 | | |
| | _ | | CONSEQUENCE OF): | | | | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| 5 | cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | |
| ∄∥ | that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| CE | | _ d | | | | | | - |
| AL. | PART II. Other significant conditi | ons contributing to death b | ut not resulting in | the underlyin | g causa given in | | NAUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | Messer | , simu | | | | 1 YES | 2 NO | COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDI | | | | | | _ | | 1 TYES 2 NO |
| Ä | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | |
| | EXAMINER? | HOSPITAL: | | THER: | ACE OF DEATH (Ch | | | |
| E | 27. MANNER OF DEATH | 1 Inpetient 2 ER/Outp | 28b. TIME (| OF 28c. IN. | URY AT | 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUP | RED |
| | 1 Natural 5 Pending | (Month, Day, Year) | INJUR | Y W | PRK7 YES 2 NO | | | |
|) BY | 2 Accident Investigatio | 28a PLACE OF IN HIDY | — At home, farm, atre | et, factory, offic | a | 281. LOCATION (Street | and Number or | Rural Route Number, |
| COMPLETED | 4 Homicide determined | | ыу) | | | City or Town, State | ") | |
| | 29a. CERTIFIER (Check only | YSICIAN: To the beat of my know | ledge, death occurred | at the time, date | and place, and due | to the cause(a) and me | nner as atated. | |
| N O | | INER: On the beals of examination | n and/or investigation, | In my opinion, | leath occured at the | time, deta and place, a | nd dua to tha d | cause(a) and manner as stated. |
| BEC | 29b. SIGNATURE AND TITLE OF CERTIF | FIER | | | 29c. LICENSE NU | MBER | 29d. DATE S | IGNED (Month, Day, Year) |
| 0 | V 9 | - | 1 | | D-2599 | 2 | > 12 | -15/90. |
| - | 30. NAME AND ADDRESS OF PERSON Khadar Baig, | | ATH (ITEM 27) (Type, P | 1,0 | | 190 18 N | | 301 Hwy |
| | 31. DATE FILED (Month, Day, Year) | 22 DECISTRADE SICH | ATURE | | ara, M | W.A. ZUU40 | | |
| | DEC 06, 30 | Grena David | 301- Pandell | • | | | | |

.

| (| | Pages 1, Program | | |
|--------------------------------|--|--|--------|--|
| BALTIMORE, MARYLAND 21203-3146 | fter death. Page 6 may be retained by the hospital or attending physician. | the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1.0 | loval. | eai examiner must be notified at once. |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, (

| | REGISTRAR | | C | ERITH | CALE | OF DEAT | Н | RI | EG. NO. | | | |
|------------------|--|---------------------------|---------------------|----------------------------|--------------------------------|-----------------------------|--------------|-------------------|-------------|-------------|------------|---|
| - 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF D | | | WEAR | 3. TIME OF DEATH |
| | HERBERT | | ALFORD | | | | | MONTH | DAY | | YEAR Qn | 6:30PM M |
| | 4. SOCIAL SECURITY NUMBER | | 5. AGE (In yrs. In: | al birthday) | IF UNDER 1 YE | AR IF UNDER | 24 HRS | 7. DATE OF B | | 4/ | | HPLACE (State or Foreign |
| V | 156 18 4946 | 1 🔀 M 2 🗆 F | 68 | YRS. | | YS HOURS | MIN. | (Month, Day | (Year) | ی ا | Count | ry) |
| | | 1 | 00 | | | | | 09 2 | 4 | 22 | | lew York |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | | WN OR LOCATIO | | NTH . | | | NTY OF E | |
| FUNERAL DIRECTOR | GLADYS NOON SPEL | I MAN NUR. | HOME | | C | HEVERL | Ϋ́ | | | Р | RINC | E GEORGE'S |
| 5 | | | | T | | | | | | | | |
| 2 | Maryland Prin | ce George | S | | , TOWN OR L | 11 22 | | | | | | 10d. INSIDE CITY LIMITS? |
| ۵ | 2 | | | Upp | er Ma | rlboro | | | | | | 1 YES 2 NO |
| 4 | 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | | 10g. CITI | IZEN OF | WHAT COUNTRY? |
| E | 12702 Sholton S | it | | | | 2077 | 2 | | | | J | JSA |
| 3 | 11-MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. A | MED | | OECENDENT O | | | | or No- | 14. RAC | E — American Indian, ik, White, atc. |
| | 1 🖰 Never Married 2 🗌 Married | FORCES? X | | NO | | s, specify Cuba YES 2 NO | | | , atc.) | | Blac | Black |
| B | 3 Widowed 4 Divorced | 11 125, 0172 1 | IN ON DAILS | | 1 | 159 2 E NO | эрвопу. | | | | Spec | *DIGCK |
| | 15. OECEDENT'S EDU | JCATION | 16a. Di | ECEDENT'S | USUAL OCCU | PATION | | 16b. KIN | D OF BUS | INESS/IND | DUSTRY | |
| ΕI | (Specify only highest grad | | 1/6 | live kind of va. Do NQT us | vork done durii e retired.) | ng most of working | ng | | | · | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) 5+ | | | ciple | | | | Pr | ivat | e | |
| COMPLETED | CT CATHERING NAME (Plan Addd 1 - 1) | | | | | | | | | | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | 715000 | Con | | | 16. MOTI | | AE (First, Middle | e, Maiden S | Surname) | | |
| BE | | Alford, | Sr. | | | | Uni | nown | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | _ | 11 | | | reet and Number | | | | | | |
| - | Ruth Ballar | d | | 3713 | S. Ge | orge M | ason | Dr/Fa | lls | Chur | ch, | Va 22041 |
| | 20e. METHOD OF DISPOSITION | | 20b. PLACE | OF DISPOS | SITION (Name | of cemetery, cren | natory or | | 20c. LOC | ATION | City or T | own, Stata |
| | 1 N Burlei 2 Cremetion 3 Ren 4 Donation 6 Other (Specify) | noval from Stata | Other p | | onv Me | morial | Park | ς | La | ndov | er. | БМ |
| | 23 SIGNATURE OF FUNERAL SERVICE L | ICENSEE | | 1 | | | | | | | | al Home |
| | (> 6 | nn- | 0 | / | | 4 Land | | | | | | |
| | Jemmy (| Hea | K/ X/ | u | | | | | | • | | .0703 |
| 10 | 23. BAT I. Enter the decases, or | compile itions that | caused tha d | aeth. Do r | ot enter the | mode of dyl | ing, such | es cerdiac | or respli | retory ar | reat, | Approximate |
| | shock, of heart fellure. IMMEDIATE CAUSE (Finel | List only one caus | ie on eech iin | a. | | / | | | | | | interval Between Onset and Death |
| | disease or condition | | 200 | 0 | A CST | | | | | | | min |
| | resulting in death) | S. DUE TO | OR AS A CONSE | OUENCE O | Pr. | 0 0 | 1 | | | | | yn y |
| | | Das | | -41. | 1 | 1 | V. | 0.0 | | | | Lance |
| 8 | Sequentially list conditions, | b. Due To | OR AS A COMSE | esul u | ce 1 | lan | for | ung | | | | lays |
| E | If sny, leading to immediate cause. Enter UNDERLYING | 7 502 10 1 | 12.00 | + | 15 | | V | | | | | 110011 |
| 일 | CAUSE (Disease or Injury | C. DUE TO | OD ASSA SONO | OUENCE O | 710 | ~ | | | | | | georg |
| ĔΙ | that initiated events reaulting in death) LAST | DOE TO | on Aga const | OULNUE O |). | | | | | | | , , |
| CERTIFICATION | | d | | | | | | | | | | <u> </u> |
| | PART II. Other significant condition | ns contributing to | death but not | resulting | In the unde | riving ceuse | givan in F | Part i. 24s | . WAS AN | AUTOPSY | 24 | b. WERE AUTOPSY FINDINGS |
| EDICAL | | _ | | - | | | | | PERFOR | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | | | | | | | | 1(| YES 2 | □ NO | | OF DEATH? |
| Z | | | _ | | | | | _ | | | - 1 | 1 YES 2 NO |
| ä | | | | | | | | | | | - 1 | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 26. PLACE OF D | EATH (Che | ck only one) | | | | |
| S | 1 YES 2 NO | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHER: | Home 5 🗆 Re | esidence (| 6 🗆 Other (Sc | ecify) | | | |
| Ŧ | 27. MANNER OF CEATH | 26a. DATE OF | INJURY | 28b. TIM | E OF 26 | c. INJURY AT | I | 28d. DEŞCRI | | JURY OC | CURED | |
| 4 | 1 Natural 6 Pending | (Month, De | ıy, Year) | IN. | IURY M | WORK? | NO I | | | | | |
| В | 2 Accident investigation | | F INJURY — At h | ome form | | | 7 | 284 LOCATIO | M /Ctmat a | and Alcomba | e or Dural | Route Number, |
| 0 | 3 Suicide 6 Could not be 4 Homicide determined | | ntc. (Specify) | ronne, tanin, | street, rectory | Office | | | wn, State) | ina numbe | n or norm | Hodie Humber, |
| ET | | | | | | | | | | | | |
| COMPLETED | | SICIAN: To the best of | my knowledge, o | leath occurr | ed at the time | , data and place | , and due | to the cause(a | and men | ner as sti | ated. | |
| MC | one) | IER: On the basis of ex | amination and/o | r investigation | on, in my opir | ion, danth occu | red at the t | time, data and | l placa, an | d dua to t | the cause | (a) and manner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFE | | 16 | | | 1 000 110 | ENDE MIN | IDED | | 204 04 | TE CLONE | D (Month Day Mar) |
| B | The same of the sa | 1 | | | | ZVC. LIC | ENSE NUM | O . | | ANG. DA | IE SIGNE | D (Month, Day, Year) |
| 10 | Anic | 4 01 | new | M | W/C | 10 | 1619 | 2/ | | - (| 11- | 47-70 |
| | 30. NAME AND ADDRESS OF PERSON W | | | | 13.5 | | , | , | - | | | |
| | James J. Ki | M. 106 | 84 Car | ~ PUS | april | 5. 6 | arg | D. M | (D). | 20 | 272 | 2 |
| | 31. DATE FILED (Month, Day, Year) | | R'S SIGNATURE | | 1 | | 1 | | | | | |
| | NOV 30 '90 | 76 - | | | V | | | | | | | |

TO BE COMPLETED BY FUNERAL DIRECTOR

| | - | age of |
|--|--|--|
| DALLIMORE, MARTLAND 21203-3146 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burial-transit permit. Page be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| 0140, | ecuted with | nd comple burial, cre |
| - \ | cate be exi | hysician are prior to |
| 5 | eath certific | sttending p |
| ,כחח | that the de | ed by the a |
| | requires v | been signe t. of Healtl |
| IN | N: The law | State Dep |
| 7 | PHYSICIA | r this certil |
| DIVISION OF VITAL RECORDS, F.O. BOA 13146, | ATTENDING | CTOR: After |
| 2 | TAL OR | RAL DIRE |
| | THE HOSF | THE FUNE fled within |
| ~ | 2 | 23 |

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

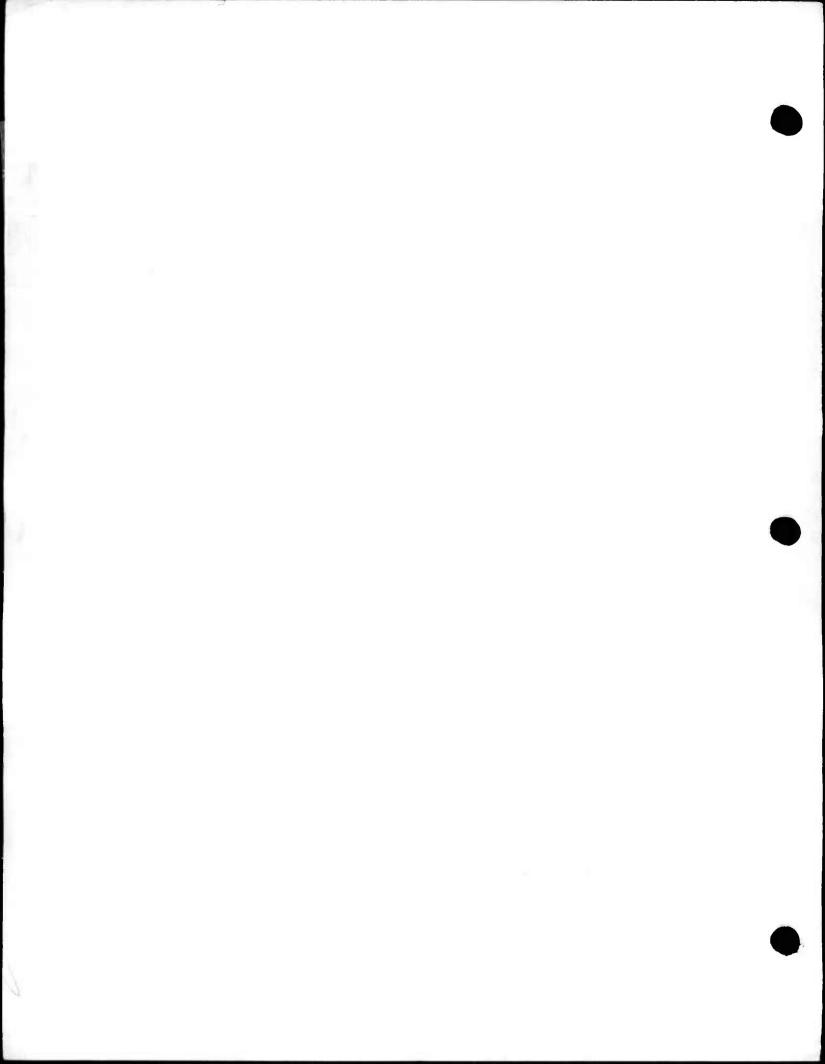
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | 1. DECEDENT'S NAME (First, | , Middle, Last) | |
|---|--|-------------------|------|
| 1 | | LANGLE | Y |
| 1 | 4. SOCIAL SECURITY NUME | | 8. |
| | 577-58-71 | | 1) |
| ı | 9a. FACILITY NAME (If not in | stitution, give s | reet |
| | 904 Jess | sica D | ci |
| 1 | RESIDENCE OF DEC | 10b. COUNTY | , |
| 1 | | | |
| ١ | Maryland | Prin | C |
| Ì | 10e. STREET AND NUMBER | | |
| | 904 Jessi | ca Dr | i |
| 1 | 11. MARITAL STATUS | | 12 |
| ı | 1 Never Married 2 | | |
| I | 3 Widowed 4 Divo | | |
| 1 | 15. DEC (Specify only | EDENT'S EDU | COT |
| ı | Element acon (any (con (an | arde | C |
| | | | |
| 1 | 17. FATHER'S NAME (First, M | liddle, Last) | |
| İ | Jesse And | derso | n_ |
| 1 | 19a. INFORMANT'S NAME (7 | | |
| | Bobbie And | | n, |
| ı | 20a: METHOD OF DISPOSIT | ION | ovel |
| ı | 4 ☐ Donation 5 ☐ Other | (Specify) | K |
| A | 21. SIGNATURE OF FUNERA | L SENVICE LIC | ENS |
| V | tures | 11/ | 1 |
| 1 | The same of the sa | 7 | - |
| ١ | 23/ PART I. Enter the d abock, or h | eert feliure. | List |
| 1 | INMEDIATE CAUSE (EL | nel / | |
| ١ | disease or condition | → ′ | _ |
| Ì | readiting in deetil) | | |
| ı | | | h |
| 1 | Sequentielly list condit If any, leeding to imme | | - |
| | cause. Enter UNDERLY | ING | |
| ı | CAUSE (Disease or Inju | iry | C |
| | thet initiated events resulting in deeth) LAS | т . | |

34291 90 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - FOR REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTA | L HYGIENE REG. NO. | 90 | 34 | 291 | |
|--|---|---|------------------------|---|------------|---------------------------------------|------------------|--|--|----------|
| 1. DECEDENT'S NAME (First, Middle, Last) | | AT 1773 1 | 33777 | 7.001 | MONT | | | EAR | E OF DEATH | |
| LANGLEY 4. SOCIAL SECURITY NUMBER | | ALVIN In yrs. lest birthday) IF | ANDE: | RSON IF UNDER 24 HRS. | 7. DATE | . 16 | | 0 3: | (State or Fore | ian M |
| 577-58-7105 | 12 M 2 □ F 46 | MO | NTHS DAYS | HOURS MIN. | | ril 9 | 194 | Country) | D C | |
| 9a. FACILITY NAME (If not institution, give street | Section in the section of the section is a section of the section | 9b | . CITY, TOWN C | OR LOCATION OF DE | EATH | | 9c. COUNTY | OF DEATH | · | |
| 904 Jessica Dr: | ive | | Fort | Washingt | on | | Princ | e Geo | rge's | _ |
| Maryland Princ | e Georges | | own or locat t Was: | hington | | | | L | NSIDE CITY JMITS? YES 2 N | 0 |
| 904 Jessica Dri | ve | | | 20744 | | | 10g. CITIZEN | S . | OUNTRY? | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | ENDENT OF HISPAN ecity Cuban, Maxica 2 X XO Specifi | n, Puarlo | N? (Specify Yea o Rican, atc.) | | RACE — An Black, White Specify: Black | • | , |
| 15. DECEDENT'S EDUCA' (Specify only highest grade co | | 16a. DECEDENT'S USL (Give kind of work | done during mo | | 16 | b. KIND OF BUSI | NESS/INDUS | TRY | | \neg |
| Elegan Grand Market | College (1-4 or 8+) | Salesman | ntired.) | | | Priva | te I | Ndust | ry | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA Edith | ME (First, | Middle, Maiden S | urname) | | | |
| Jesse Anderson 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | and Number or Rural | Route Nun | nher City or Town | State Zin Co | rde) | | - |
| Bobbie Anderson | , Wife | | | a Drive | | | | | Md20 | 744 |
| 20a: METHOD OF DISPOSITION 1 Deurlai 2 Cremation 3 Ramovi 4 Donation 5 Other (Specify) | of Horn Chata | exyland | | | | | | or Town, St. | land | |
| 21. SIGNATURE OF FUNERIAL SERVICE LICEN | ISEE | aryıand | 22. NAME A | son & J | 7 | 16 Ken | nedy | St. | NW20 | 011 |
| /iMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | | Sunshot Wo consequence of: | und of | Chest | | | | | interval Bet Onset and | |
| Sequentielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| CAUSE (Disease or Injury thet initiated events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | | |
| PART II. Other significent conditions | contributing to death b | out not reculting in t | he underlyin | g ceuse given in | Pert i. | 24s. WAS AN A PERFORM 1 X YES 2 | AED? | COMP DF DE | AUTOPSY FIN ABLE PRIDR TO LETION DF CA ATH? YES 2 NO | USE |
| | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | 100 | 26. PL | ACE OF DEATH (Ch | eck only o | one) | | | | |
| | ☐ Inpatiant 2 ☐ ER/Outp | | ☐ Nursing Hom | ne 5 X Realdenca | | er (Specify) | IIIIV COO: | 150 | | |
| 1 Natural 5 Pending | (Month, Day, Year) 11-16-90 | 1:49 F | WO | PRK? | | abject : | | | | |
| 2 Accident Investigation XXX Suicide 8 Could not be | 28a. PLACE OF INJURY building, atc. (Spec | - At home, farm, atres | | ~ | | CATION (Street ar | | | umber, | \dashv |
| 4 Homicide determined | and open | hor | me | | Ft | . Wash: | 904 Jo inator | essica 1. P.C | Dr., Co. | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA 2 MEDICAL EXAMINER: | AN: To the best of my know On the baels of axamination | | | | | | | ause(a) and i | MD nanner ae sta | ited. |
| 290. SIGNATURE AND TITLE OF CERTIFIES | 0 | | | 29s. LICENSE NUR | | | | IGNED (Mont) | | |
| AV | XX | | | OCME | | | • 1 | 1-17- | 90 | |
| Arm M. Dixon, M. | | | | nn Street | ь, В | altimor | e, MD | 2120 |)1 v | 1 |
| Ann M. Dixon, M. 31. DATE FILED (Month, Day, Year) NOV 2 7 '90 | Julia Davidson | fandell. | | | | | - | | | |

DHMH-18 Rev 1/89



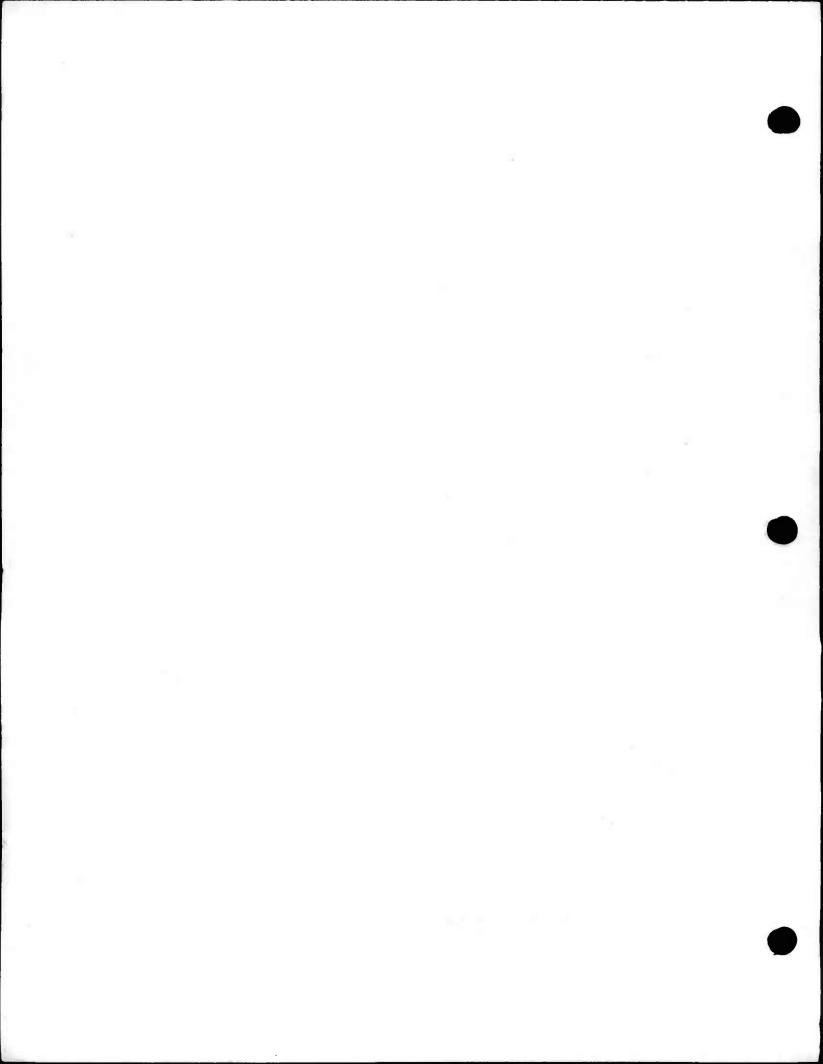
| he hos | detach | Once. |
|--|--|--|
| TO THE MOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within a secure death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detach be filed within 72 hours after death with the State Dent of Health and Mental Molene prior to build in premation or removal | IMPORTANT. If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| retaine | 5 shou | notifie |
| ay be | page | t be |
| је 6 п | rector, | mus |
| th. Pag | neral di | miner |
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| within | pletely | ent, t |
| cuted | d com | tic ev |
| be exe | ian an | auma |
| ficate | physic ne pric | her tr |
| h certi | Hvnie | or of |
| ne deat | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filled within 72 hours after death with the State Dent, of Health and Merial Houlene prior to burdal memoring | jury, |
| that th | band by | amy Ir |
| quires | n signe | OWS |
| law re | as bee | 23 sh |
| I: The | cate hi | tem |
| SICIAN | certification of | 0 |
| 3 PHY | ir this | arked |
| NDIN | R: Afte | S E |
| ATTE | ECTO! | n 28 |
| AL DR | AL DIR | If Item |
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| 2 | 2 4 | IMP |

| | STATE REGISTRAR DECEDENT'S NAME (First, Middle, Leat) Anna | | MARYLAND C | ERTIF Ami | ICAT | E OF | DEA | TH | 2. DAT | REG. NO E OF DEATH TH1/30 | | YEAR | 3. TIME OF DEATH |
|----------------------|---|--|--------------------|---|--------------------------------------|------------------|----------------------|-----------|------------------|----------------------------------|---------------|-------------------|---|
| | 4. SOCIAL SECURITY NUMBER 187-18-1786 | 5. SEX | 6. AGE (In yrs. Is | isl birthday) | | R 1 YEAR | IF UNDER | 24 HRS. | 7. DATE | E OF BIRTH | | a. BIRTH Count | PLACE (State or Foreign |
| | 9a. FACILITY NAME (If not institution, give | | | YRS. | 05-017 | Y, TOWN C | | | | 8/30/0. | | | aly |
| TOR | Anne Arundel M | | nter | | | nnapo | | ON OF DE | EATH | | | nty of b | rundel |
| DIRECTOR | 10a. STATE NOB. COUNT AN | ne Arunde | 1 | 10c. CIT Ar | y, town | OR LOCAT | TION | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER Chesapeake Man | or N.H. | | | | 101 | . ZIP CODI | 210 |)12 | | 10g. CU. | ZEN OF Y | /HAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE W | YES 2 | RMED | 13. | If yes, spe | ENGENT Conclety Cuba | n, Maxica | n, Puarto | IN? (Specify Yes Rican, atc.) | or No- | Black | - American Indian, White, stc. |
| COMPLETED | 15. DECEDENT'S EDI (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5 + | | ECEDENT'S Give kind of v B. Do NOT us | USUAL (vork done se retired.) | during mos | ON st of workin | ng | 16 | b. KIND OF BUS | SINESS/IND | | |
| MP | 5 | | | Seams | tres | SS | | | | Cloth | | acto | ry |
| | 17. FATHER'S NAME (First, Middle, Last) ROCCO Giabbarre | ogi | | | | | | | | Middle, Maiden | Surname) | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 521 | 16 | b MAILING | ADDRES | e /Stenet e | | seph | | nber, City or Town | | | |
| 욘 | Mrs. Eleanor B | ird | | 128 J | | | | | | Pasader | | | D 21122 |
| | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremation 3 Ren 4 Donatton 5 Other (Specify) | noval from State | | OF DISPOS | | | | | | | CATION — | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | CENSUE | | 1 | | NAME AN | | | | 495 F Home Se | | | wy. rk MD 21146 |
| | 23. PART i. Enter the diseeses, or shock, or heert feliure. | complications that | coused the de | eeth. Do n | ot ante | r the mod | de of dyl | ng, aucl | h ee cer | diac or respi | ratory err | eet, | Approximate |
| | iMMEDIATE CAUSE (Final disease or condition resulting in deeth) | · Pr | neum | on | _ | | | | | | | | Interval Between Onset end Death |
| NO | Sequentially list conditions. | b | OR AS A CONSE | | | | | | | | | | |
| CERTIFICATION | if any, leeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | C | OR AS A CONSE | | | | | | | | | | |
| H | reaulting in death) LAST | d | | | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other algnificent condition 9(15/70) INE MEMBER H | e contributing to | deeth but not | recuiting i | n the u | nderlying | ceuse g | liven in | Pert i. | 24a. WAS AN PERFOR | MEO? | 24b. | WERE AUTOPSY FINOINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| A | 25. WAS CASE REFERRED TO MEDICAL | | | | | 26. PI | ACE OF DE | EATH (Cha | ock only o | 201 | | Ш_ | NIA. |
| Sic | EXAMINER? | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | | | | | - | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. OATE OF (Month, Da | | 28b. TIME | OF | 28c. INJU WOF | JRY AT | | | SCRIBE HOW IN | JURY OCC | UREO | |
| COMPLETED BY | 2 Accident Investigation 3 Suicide 6 Could not be determined | 28e. PLACE OF building, a | INJURY — At he | oma, farm, a | treet, fac | | | | 281. LOC City | CATION (Street a or Town, State) | nd Number | or Rural A | oute Number, |
| J.E | 29a. CERTIFIER (Check only | CIAN: To the best of | my knowledge, de | eth occurre | d at the 1 | lime, data | and place, | and dua | to the ca | use(s) and man | ner aa state | ıd. | |
| ž | one) 2 MEDICAL EXAMINE | R: On the basis of ax | amination and/or | Investigation | n. In my | noinies de | ath occur | ad at the | lime data | and alees | d along to at | | |

296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type-Print)

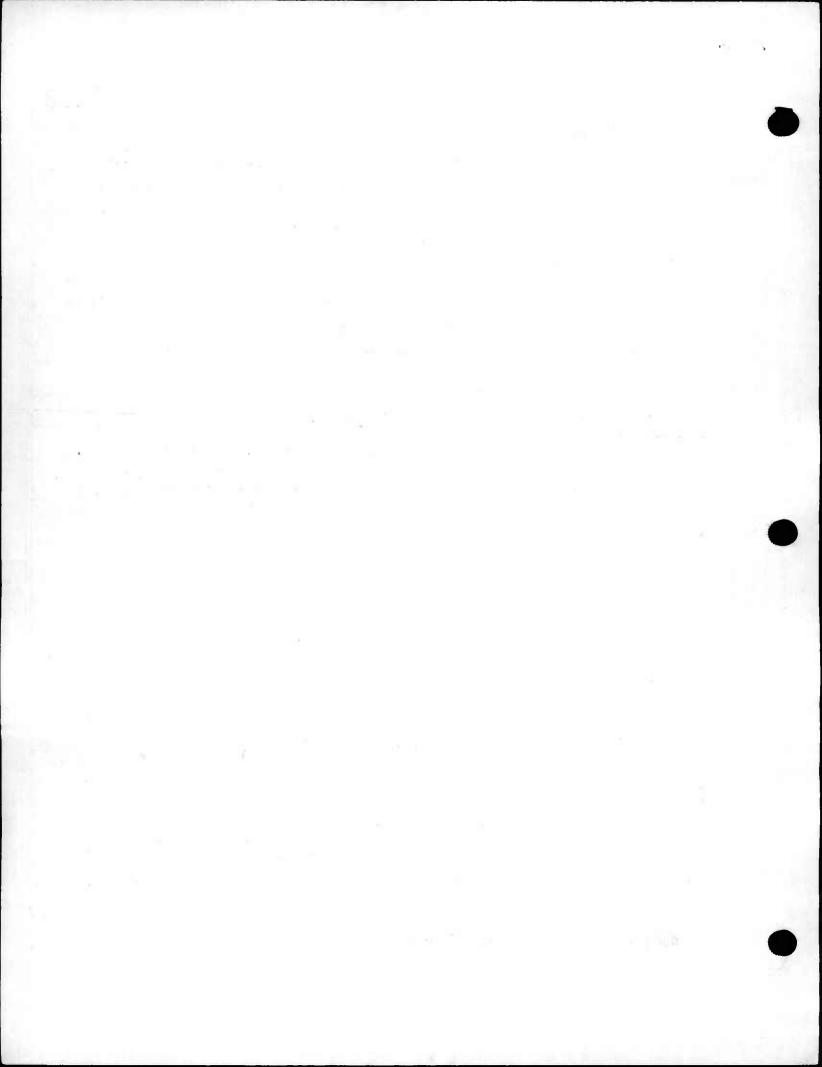
THOMAS WASH M.D. 269 PENNINSULU

31. DATE FILED (Marith 1990) Julia Washestern Paradone



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| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | | F HEALTH AND | MENTAL | HYGIENE REG. NO. | 9 | 0 34 | 293 |
|--|---|--|------------------------------|----------------------------|--|---------------------|-----------------------------------|--------------|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last | | D | | | 2. DATE O | OF DEATH | 5 0 | EAR 2 | OF DEATH |
| P) | 4. SOCIAL SECURITY NUMBER 21209 6509 | 5. SEX 6. AGE | (In yrs. last birthday) YRS. | IF UNDER 1 YE | EAR IF UNDER 24 HRS. AYS HOURS MIN. | 7. DATE C | | V. 6. | BIRTHPLACE (St Country) Marvlan | |
| TOR | 9a. FACILITY NAME (If not institution, given SINA! HOSPIT | | rimore | 96. CITY, TO | WN OR LOCATION OF DI | | | 9c. COUNTY | OF DEATH | |
| HE | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | BEITY | | Y, TOWN OR L | OCATION OTTE | | | | 10d. INSI | |
| IA I | 100. STREET AND NUMBER | PRS AVE | | | 101. ZIP CODE | 09 | | • | N OF WHAT COU | |
| BY FUNER | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | 2 X NO | If ye | DECENDENT OF HISPAI es, specify Cuben, Mexico YES 2 NO Specifi | nn, Puerto R | | or No- 14 | RACE — Americ Black, White, e Specify: | |
| ETED | 16. DECEDENT'S EL (Specify only highest gra Elementary/Secondary (0-12) | DUCATION de completed) College (1-4 or 5+) | Ilfe. Do NOT u | work done during retired.) | PATION ng most of working | 16b. | KIND OF BUS | | | |
| COMPL | 12 17. FATHER'S NAME (First, Middle, Last) | И 1 В П | 100 | etary | 16. MOTHER'S NA | AME (First, M | liddle, Malden S | | | |
| TO BE | 19a. INFORMANT'S NAME (Type/Print) | Howard R. P | 19b, MAILING | | treet and Number or Rural | Route Numb | | | Zeigler | |
| 2 | Bessie W. Harre 20a_METHOD OF DISPOSITION 1 | 200 | b. PLACE OF DISPO | | of cemetery, crematory or | | | | y or Town, State | |
| examiner must | 21. SIGNATURE OF FUNERAL SERVICE | | Leasant | | ME AND ADDRESS OF FA | | | | ills, M terstow | |
| al Hygiene prior to burial, cremation, or removal or other traumatic event, the medical ERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events) | DUE TO (OR AS A | | P): | NRE | | | | | erval Between set and Death |
| E 5 0 | resulting in death) LAST | d | | | | | | | | |
| hows any I | PART II. Other significant condition | ona contributing to death t | out not resulting | In the under | riying ceuse given in | Part I. | 24a. WAS AN PERFOR | MED? | AMAILABL COMPLET DF DEATH | TOPSY FINDINGS E PRIDR TO TION DF CAUSE H? B 2 \(\text{NO} \) |
| State Dept. Item 23 | 25. WAS CASE REFERRED TO MEDICAL, EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF DEATH (C) | heck only one | n) | | - | |
| \$ 0 C | 1 YES 2 NO 27. MANNEB OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 Inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) | 28b, TIN | E OF 28- | thome 5 Residence c. INJURY AT WORK? I YES 2 NO | | (Specify) | JURY OCCU | RED | |
| 775 | 3 Suicide 6 Could not b 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, celly) | street, factory, | , office | 28f. LOCA City o | TION (Street e or Yown, State) | nd Number or | Rural Route Numi | ber; |
| within 72 hours after ANT: If Item 28 is | | SICIAN: To the best of my know NER: On the basis of examination | | | | | | | | iner as stated. |
| be fled within 72 ho IMPORTANT: If Its | 204. SIGNATURE AND TITLE OF CONTROL | there is | 4 | | 29c. LICENSE NU | MBER | | 29d. DATE S | IGNED (Month, D | lay, Year) |
| | | enn G | VIRAT | A Print) | | | | | | |
| | 31. DATE FILED (Morith, Day, Year) NOV 29 '90 | 32. REGISTRAR'S SIGN | Pandall. | | ^ | | | | | |

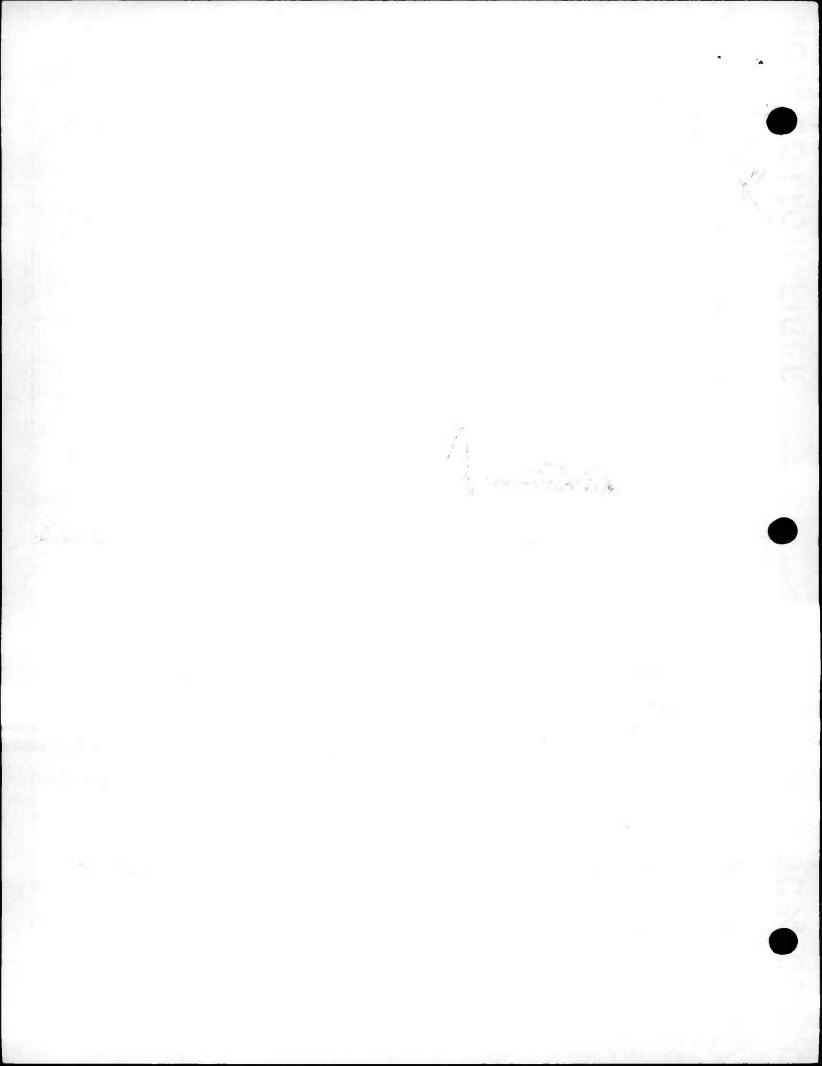


| 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | DALLIMONE, MARILAND |
|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within Zarouns after death. Page 6 may be retained by the hospi | mours after death. Page 6 may be retained by the hospi |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the find within 72 hours after death with the State Decr of Health and Mental Hynliene polor in burial community or named. | led in by the funeral director, page 5 should be detached |
| IMPORTANT: It Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | medical examiner must be notified at once. |

31. DATE FILED (MORTH, Day, Year) 90

| 7 | 1 - STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Lest) | STATE OF I | С | ERTIF | ICATE | OF I | DEA | TH | 2. DATE O | REG. NO. | | | |
|---|---|-------------------|--------------------|--------------|-------------------------------|-------------------|-----------|--------------|--|--------------------------------|-------------|------------------------|---|
| 1 | Lerah In | | rrier | | | | | | NOV. | 28 | 3, 19 | 190 E | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 220-34-6526 | 5. SEX | 6. AGE (In yrs. le | yrs. | | _ | IF UNDER | R 24 HRS. | | F BIRTH Day, Year) 7,19 | | Country) | ACE (State or Foreign |
| 27 | 9a. FACILITY NAME (If not institution, give | | | | 9b. CITY, T | OWN OF | | 1 | EATH | 1,19 | | TY OF DEAT | land H |
| - | Carroll Co.Ge | neral H | ospita | 1 | | Wes | tmi | inst | er | er Carroll | | | |
| | 10a. STATE 10b. COUNT | • | | 10c. CIT | | | | od | | | | | LIMITS? |
| | 100. STREET AND NUMBER 138 Pipe Cree | k Road | | | | 101. 2 | ZIP COD | 1764 | | | | EN OF WHA | T COUNTRY? |
| | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 | YES 2 | RMED NO | l lf y | es, spec | Ify Cubi | an, Mexica | n, Puerto Ric | (Specify Yes can, etc.) | | 14. RACE — Black, W | American Indian, hite, etc. |
| | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5 | +) | a. Do NOT u | work done dur se retired.) | ing most | of worldi | ing | 16b. K | IND OF BUS | SINESS/INDU | STRY | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | TOME | make | | 16. MOT | HER'S NA | ME (First, Mid Wach | ter | Surname) | | |
| | 190. INFORMANT'S NAME (Type/Print) Doris R. Arba | ugh | 16 | 38 F | ADDRESS (S | Street and Cre | Number | r or Rural I | ural Route Number, City or Town, State, Zip Code) d. Linwood, Maryland 2 | | | | |
| | 20s. METHOD OF DISPOSITION 1 | ioval from State | ther o | (ace) | | | | - | erv | | | | 1775 |
| - | 21. SIGNATURE OF FUNERAL SERVICE LI | Hernu | 1, 8. | | 22. NA | ME AND Bur | ADDRE | ss of fa | uner | al H | ome | | 7 110. |
| | 23. PART I. Enter the diseases, or ahock, or heart feliure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. PN | 2UMB | ma | <u></u> | e mode | of dy | ing, suci | h aa cardla | c or reepl | ratory erre | at, | Approximate Interval Between Onset end Death |
| | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c | | | | | | | | | | | |
| | PART II. Other eignificent condition Anama Act y Graman | fficien | El . | | , | | | given in | | PERFOR | MED? | CO OF | AILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | MOSPITAL: | | | | 26. PLA | CE OF D | EATH (Che | ck only one) | | | | |
| ۱ | | 1 Sinpatient 2 | | | 4 - Nursin | | | esidence | | | | | |
| THE RESIDENCE OF DECEDENT THE STREET MAD PUMBER 10 STREET AND PUMBER 11 SAS PIPE Creek Road 10 STREET AND PUMBER 11 SAS PIPE Creek Road 10 STREET AND PUMBER 11 SAS PIPE Creek Road 11 SAS PIPE Creek Road 12 SAND 12 SAND 12 SAND 13 SAND 14 SAND 15 SAND 16 STREET AND PUMBER 16 SAND 17 SAND 17 SAND 18 SAND 19 SAND 19 SAND 10 SAND 10 SAND 10 SAND 10 SAND 10 SAND 10 SAND 10 SAND 10 SAND 11 SAND 11 SAND 12 SAND 12 SAND 13 SAND 14 SAND 15 SAND 16 SAND 16 SAND 17 SAND 17 SAND 18 | | | | | | | | | | | | | |
| - | 4 Homicide determined | building, | etc. (Specify) | ome, farm, : | Rreet, factory | , office | | | 28f. LOCATI City or | ION (Street a. Town, State) | nd Number o | r Rural Route | Number, |
| | 29a. CERTIFIER (Check only one) CERTIFVING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. Discretely included the cause(b) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | propore | e Rod | 2 | | 2 | | O 1 | OTC | 7 | 29d. DATE | SIGNED (MO | infr. Day, Year) |
| I | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Dipo. Print) | | | | | | | | | | | | |

32. REGISTRAR'S SUGNATURE FUNDA SUMMERSON - ROYALDE



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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2. Justin after death. Page 6 may be | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page be fleet within 72 hours after death with the State Dept. of Heath and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be |
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PHYSICIAN: MEDICAL CERTIFICATION

BY

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30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF GEATH (ITEM 27) (Type, Print)

NADE

190 0

31. DATE FILED (Month, Day, Year)

ASS F

32. REGISTRAR'S SIGNATURE

wha Savidson Randall

34295 90 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH 1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH ELLEN BROW ONA 7030 90 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH (Month, Day, Year) OCT. 18, 1904 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 8. BIRTHPLACE (State of DAYS HOURS 1 M 2 KF MARYLAND 215-38-1028 86 YRS 9e. FACILITY NAME (If not institution, give street end number) 9c. COUNTY OF GEATH 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE BALTIMORE GOOD SAMARITAN HOSPITAL RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND BALTIMORE 1 YES 2 NO BALTIMORE 10e. STREET AND NUMBER 101. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 6803 BARNETT ROAD 21239 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 10 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-if yes, specify Cuben, Mexican, Puerto Ricen, atc.) 14. RACE — American Indien, Black, White, atc. 1 Never Merried 2 X Merrie IF YES, GIVE WAR OR DATES 1 YES 2 X NO Specify: 3 Widowed 4 Divorced WHITE 18a. DECEDENT'S USUAL OCCUPATION

The day work rione during most of working 15. DECEDENT'S EDUCATION 18b. KINO OF BUSINESS/INDUSTRY (Specify only high (Give kind of work done life. Do NOT use retired.) College (1-4 or 5+) Elementary/Secondary (0-12) SEAMSTRESS **FACTORY** 11 YEARS 2 YEARS 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) **GRAHAM** ANNIE GILLIS WILLIAM (unk) 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6803 BARNETT RD, BALTIMORE, MD 21239 WILLIAM R. BROWN-SON 20g, METHOD OF DISPOSITION 12/1/90 1 X Burlel 2 Cremetion 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetery or 26c. LOCATION — City or Town, State MARDELA MEMORIAL CEMETERY MARDELA SPRINGS, MD 4 Donation 5 Other (Specify) . 22. NAME AND ADDRESS OF FACILITY
HOLLOWAY FUNERAL HOME, PA 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 501 SNOW HILL RD, SALISBURY, MD 21801 23. ART I. Enter the diseases, or complications that caused by each. Do not antar tha mode of dying, such as cardiac or respiratory arrest, Approximsta ahock, or haart fallure. List only one cause on intarvai Betwe Onset and Death IMMEDIATE CAUSE (Final disease or condition resulting in death) avest ofe Sequantially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate Seizme cause. Enter UNDERLYING activity CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in dasth) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 24a, WAS AN AUTOPSY 1 YES 2 NO DF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL:
1 Eximpatient 2 ER/Outpatient 3 DOA OTHER: 1 | YES 2 | NO 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28e. DATE OF INJURY 28b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 🔀 Natural 1 YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be 4 Homicide 29e. CERTIFIER

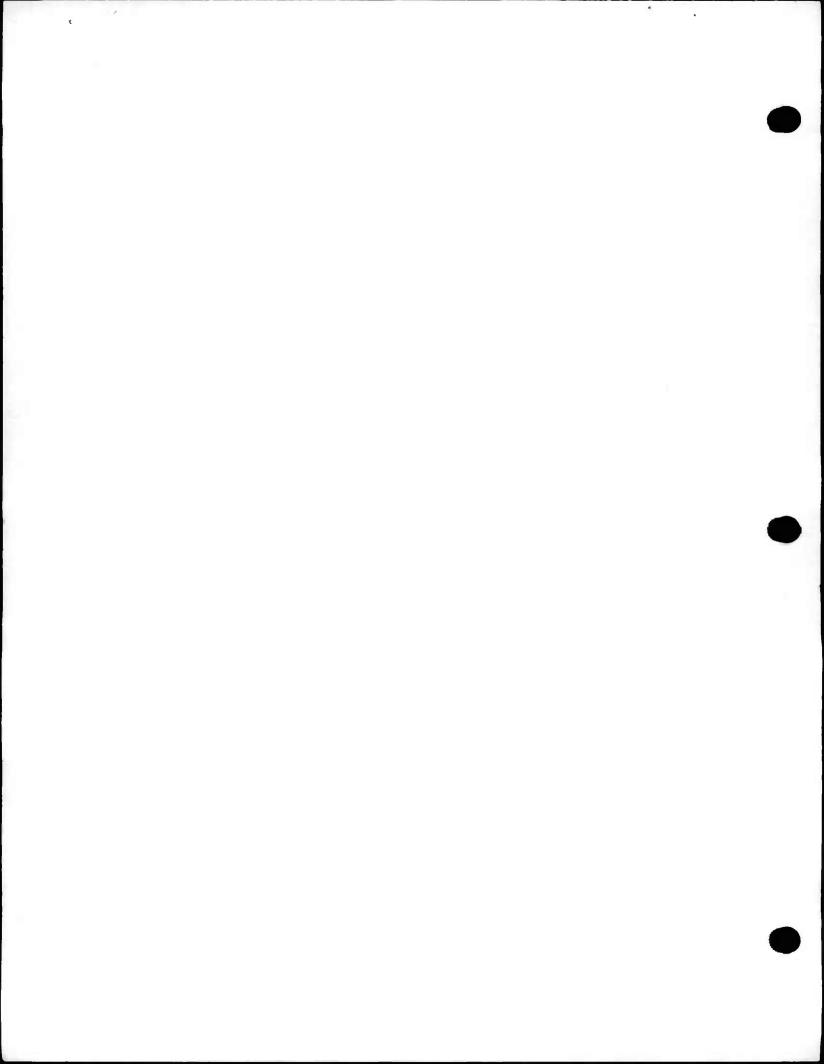
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(a) and manner se stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and piece, end due to the ceuse(a) and manner as atteted. 295 SIGNATURE AND TITLE OF CERTIFIER 29d. OATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER Nader Kussem MD

600d

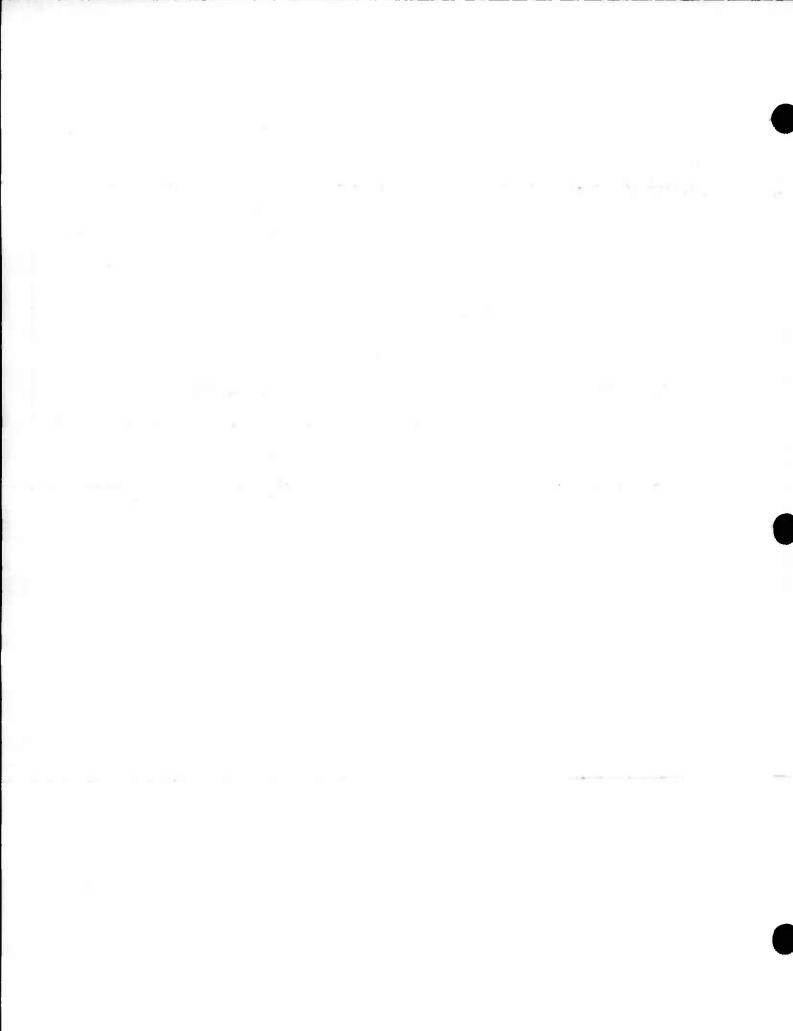
Samonton

DHMH-16 Rev 1/89

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| | | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF | | | YGIENE EG. NO. | | | | |
|---|-----------|--|--|--|---|--|---------------------------------------|--------------------------------------|---------------------------------|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | JAMI | ES A. | B | rown | 2. DATE OF MONTH | DAY | YEAR 3. | TIME OF DEATH | | |
| (P |) | | | 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF 1 (Month, Pa 7 / 2 / | | s. BIRTHPLA Country) Mary | Tand | | |
| 2, 3 sho | CTOR | 9a. FACILITY NAME (If not institution, give stre PENINSULA GENERAL | | | SALIS | OR LOCATION OF OR BURY | EATH | 9c. COU | COMICO | H H | | |
| August A representations | DIREC | 10a. STATE 10b. COUNTY Maryland Wie | comico | | y, town on Local | Spring: | s | | | d. INSIDE CITY LIMITS? YES XX NO | | |
| physician. burial-transit permit. Pages | FUNERAL | Rt. 1, Box 28 | 85 | | | 01. ZIP CODE 21837 | | | ZEN OF WHA | T COUNTRY? | | |
| attending physician se as the burial-trai | В | 11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Olvorced | 12. WAS OECEOENT EVER IN FORCES? 1 X YES IF YES, GIVE WAR OR DAT | 2 NO | If yes, s | CENDENT OF HISPAI pecify Cuben, Maxica S 2 X NO Specif | en, Puarlo Rica | | Black, W | American Indian, Inte, etc. Black | | |
| al or for u | LETED | 15. DECEDENT'S EDUCA (Specify only highest grade of Elamentary/Secondary (0-12) | ATION ompleted) College (1-4 or 5+) | 16a. OECEDENT'S (Give kind of the Do NOT us) Jani | work done during n se retired.) | | | | Hospital Conmental Serv. | | | |
| by the hospital be detached for at once. | E COMPL | 6th 12. FATHER'S NAME (First, Middle, Last) Verlon Brown | | Odiii | 01 | COGRE | AME (First, Midd. | le, Malden Surname) | | | | |
| retained 5 should notified | TO BE | 19a. INFORMANT'S NAME (Type/Print) Dorothy M. Bro | Route Number, (| | r Town, State, Zlp Code) prings MD 21837 | | | | | | | |
| Page 6 may be al director, page ner must be | | 4 Donation 5 Other (Specify) | 20c. LOCATION Donation 5 Other (Specify) | | | | | | | | | |
| Jeath. | | 21. SIGNATURE OF FUNERAL SERVICE LICE | Eshon | | | amptom- Box 43 | Hawki | ns Funei eralsbui | al H | ome D 21632 | | |
| 24 nours at filled in by on, or remo | | 23. PART I. Enter the diseasee, or co- ehock, or heert fellure. L. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | let only one ceuee on ee | the line. | -for | | | | | Approximate Interval Between Onset and Death | | |
| executed and corr o burial, natic ev | CATION | Sequentially list conditione, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| th certificat ending phy I Hygiene p | RTIFI | thet Initiated evente resulting in deeth) LAST DUE TO (OR AS A CONSEQUENCE OF): Or DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| by the and Me | MEDICAL C | 1 TES 2 NO | | | | | | | | | | |
| DR ATTENDING PHYSICIAN: The law requires the UNECTOR: After this certificate has been signed hours after death with the State Dept. of Health tem 28 is marked, or Item 23 shows an | SICIAN: | | HOSPITAL: | | OTHER: | PLACE OF OEATH (C) | | | | | | |
| NG PHYSICIAN fler this certifi eath with the S marked, or | PH | 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | P Inpatient 2 PA/Outpe 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIN | IE OF 28c. If | NJURY AT YORK? | | BE HOW INJURY OC | CUREO | | | |
| DR ATTENDING F DIRECTOR: After 1 hours after death | ETED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, atc. (Specif | At home, farm, | street, factory, off | lca | 28f. LOCATIO | ON (Street and Number own, State) | or Rural Rout | e Number, | | |
| 7 72 - | COMPLE | anni | EIAN: To the best of my knowle t: On the bests of axamination | | | | | | | nd manner as stated. | | |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 h IMPORTANT: If I | 핆 | 29b, SIGNATURE AND THIS OF CERTIFIER | 190 | | | D 2 0 4 4 1 | MBER | 29d, DAT | E SIGNED (M | onth, Day, Year) | | |
| | D TO | Dr. Joseph Rass | etto, Locu | | | Sts.,Sa | lisbu | ry, MD | 21801 | | | |
| | 2 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | | | | | | | | | |



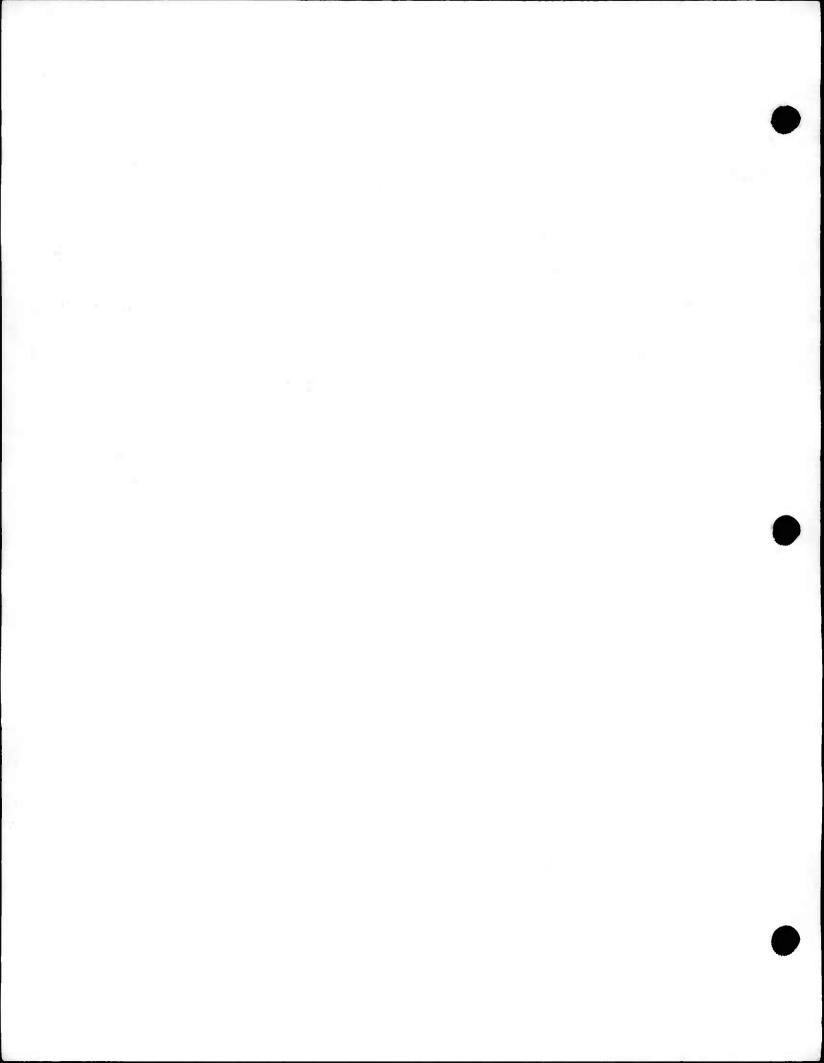
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| | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, NOV 28 '90

TO BE COMPLETED BY FUNERAL DIRECTOR

| | | | | | | | | | | | 90 | 34297 |
|--|-----------------------|-----------------------------|-------------------|---------------------------|------------------|-----------------|---------------------|---------------|--|---------------|-------------------|----------------------------------|
| 1 - STATE REGISTRAR | | STATE OF N | MARYLA | AND / DEPAR | RTMEN | T OF H | EALTH AND | MEN | ITAL HYGIEN | | | |
| 1. DECEDENT'S NAME (First, M | Middle Last) | | | OLITTI | ICAI | LOF | DEATH | _ | REG. NO | | | |
| | | CILADIA | r | | 0 | | 1.4 | 2. 1 | DATE OF DEATH | AY | YEAR | 3. TIME OF DEATH |
| WILLIE 4. SOCIAL SECURITY NUMBER | | CHARLIE | | | R | FRR | ett | 0 | lovember | 20 | 1990 | 1020 |
| 4. SOCIAL SECURITY NUMBER | H | 5. SEX | 6. AGE (// | n yrs. last birthday) | IF UNDE | DAYS | IF UNDER 24 HRS | 7.0 | Month, Day, Year) | 150 (0) | 8. BIRTHI | PLACE (State or Foreign |
| 330.0,1-01 | 065 | 1 X M 2 - F | 8 | 1 YRS. | WONTHS | DATS | HOURS MIN. | | 2/09 | | | th Carolina |
| 9e. FACILITY NAME (If not instit | itution, give st | reet and number) | | | 9b. CIT | Y, TOWN | OR LOCATION OF | | | 9c. COU | INTY OF DE | |
| PENINSULA GE | NERAL | HOSPITA | Ĺ | | | ALISE | | | | - | COMIC | |
| RESIDENCE OF DECE | | | | | | | | | | 1 | | |
| 10e. STATE | 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10d. INSIDE CITY |
| Maryland | Wicon | nico | | Ma | rdela | a Spr | ings | | | | | LIMITS? 1 YES 2 NO |
| 10e. STREET AND NUMBER | | | | | | | . ZIP CODE | | | 10g, CIT | | HAT COUNTRY? |
| Rt. #2, Box 6 | 4. A+ | nol Road | | | | 1 | 1837 | | | | | |
| 11. MARITAL STATUS | 2 1 9 2 X LI | 12. WAS DECEDEN | EVER IN | U.S. ARMED | 12 | | | ANICO | RIGIN? (Specify Yes | | ISA | |
| 1 Never Merried 2 Me | erried | FORCES? 1 IF YES, GIVE W | YES | 2 X NO | " | If yes, sp | scify Cuben, Mexi | Ican, Pu | erto Ricen, etc.) | or No- | 14. RACE Bleck | American Indian, White, atc. |
| 3 Widowed 4 Divorce | ed | IF TES, GIVE W | AH OH DA | IES | | 1 [YES | 2X NO Spe | cify: | | | Specifi | |
| 15. DECED | ENT'S EDUC | ATION | | 18e. DECEDENT'S | INCLIAL C | COURATIO | | | | | | <u>an America</u> |
| (Specify only hi | ighest grade (| completed) | | (Give kind of a | work dona | during mo | st of working | | 18b. KIND OF BUS | SINESS/IND | DUSTRY | |
| Elementery/Secondery (0-12 6th grade | " | College (1-4 or 5+ |) | | , | | | | 0.10 | | | |
| 17. FATHER'S NAME (First, Middle | (for 1) (d) | | | retired - | - Iar | <u>mer</u> | | | Self-emp | | d | |
| | | | | | | | | | irst, Middle, Maiden | Sumame) | | |
| Robert L. Bar | | | | | | | Minnie | | | | | |
| 19e. INFORMANT'S NAME (Type | | | | 19b. MAILING | ADDRES | S (Street a | nd Number or Rura | il Route | Number, City or Town | n, State, Zlp | Code) | |
| Josephine Thon | npson | | | Rt. #1 | , Bo | x 35 | 5. Eden. | Ma | ryland 2 | 21822 |) | |
| 20e. METHOD OF DISPOSITION 1X Burlel 2 ☐ Cremetion | 2 🗆 🗅 | -14 | 20b. | PLACE OF DISPOS | SITION (N | ama of cen | etery, crematory or | | | | City or Tow | n. State |
| 4 Donetion 5 Other (Sp | oecify) | val from State | | other place) pringhill | | | | | | | · | |
| 21. SIGNATURE OF FUNERAL S | SERVICE LICE | NSEE | 10 | Dilligilli | 22. | NAME AN | D ADDRESS OF F | ACILITY | Jolley M | bron, | Mary | yland |
| Vat. | | 11/ | Paul | 1.11 | R | t. #2 | Box 92 | 00 - | Joney M | emor | Tal C | hapel bury, MD |
| Paint. | XX | MICHO | asn | illy | | 11 2 | , DOX 72 | .0, | ersey K | Jau, . | Jansu | dry, MD |
| 23. PART I. Entar the dise shock, or hear | rt fallura. L | iat only one caus | causad e on aa | tha death. Do n | ot antai | r tha mod | da of dying, su | ich as | cardiac or respi | ratory arr | reat, | Approximate |
| IMMEDIATE CAUSE (Final | | 13 | 0 | | | | | | | | | Intarval Batween Onsat and Death |
| disease or condition resulting in death) | | Ca | 1de | re - | 10- | - 6 | · · For | | e | | ` | |
| in doudly | a | DUE TO | OR AS A C | ONSEQUENCE OF |): / | Hot | 27-19 | | 775 | | | - |
| | | R | /, | . o. Te | | | | | | | | i |
| Sequantially list condition if any, leading to immediat | | DUE TO | DA AS A C | CONSEQUENCE OF | i i | | - | | | | | |
| cause. Entar UNDERLYING | | 0: | 11 | | | - 70 | | 1 | | | | Ĭ. |
| CAUSE (Disease or injury that initiated avents | 1 " | DUE TO | OR AS A C | ONSEQUENCE OF | e ac | 1-40 | 4079 | er | 22 2 | | | i |
| resulting in death) LAST | | / | 1 | | | | | | | | | î |
| | C d. | | | | | | | | | | | |
| PART II. Other algolificant | conditions | contributing to | leath but | not resulting in | n tha ur | ndarlying | cause given in | n Part I | . 24a. WAS AN | MITOPSY | 24h 1 | WERE AUTOPSY FINDINGS |
| | | | | | | | | | PERFORI | MED? | 1 7 | AVAILABLE PRIDE TO |
| | | | | | | | | | 1 - YES 2 | M NO | | CDMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | 1 | 1 YES 2 NO |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO M | | HOSPITAL: , | /_ | | | | CE OF DEATH (C | heck ont | y one) | | | |
| 1 TYES 2 NO | 7 | 1 Inpetient 2 | ER/Outpat | lent 3 🗆 DOA | OTHER 4 Num | | 5 Reeldence | a \square o | ther (Specify) | | | |
| 27. MANNER OF DEATH | | 28e. DATE OF I | YJURY | 28b. TIME | OF | 28c. INJU | RY AT | | DESCRIBE HOW IN | JURY OCC | URED | |
| | nding eatigation | (Month, De | , reur) | INJU | JRY M | WOF | IK? ES 2 NO | | | 550 | | |
| • 🗆 • • • • • • • • • • • • • • • • • • | | 28e. PLACE OF | INJURY - | - At home, ferm, st | treet, face | | | 204 1 | OCATION /Dens: | ad Alice 6 | 0 - 15 | |
| | ild not be erminad | building, a | c. (Specify |) | 201, 1801 | or \$1 or night | | 401. (| OCATION (Street ar City or Town, State) | nu Number | or Hural Ros | ite Number, |
| 29e. CERTIFIER | | 17.53 | | | | | | | | | | |
| (Check only | ING PHYSICI | AN: To the best of n | y knowled | ige, death occurred | d at the ti | lme, date e | end plece, end du | e to the | ceuse(e) end menr | ter ee state | ed. | |
| 2 MEDICAL | L EXAMINER: | On the beele of exa | minetion e | nd/or investigation | . In my o | minion 4- | eth accurred et 16. | a dima | lada anad otano | | | |



FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

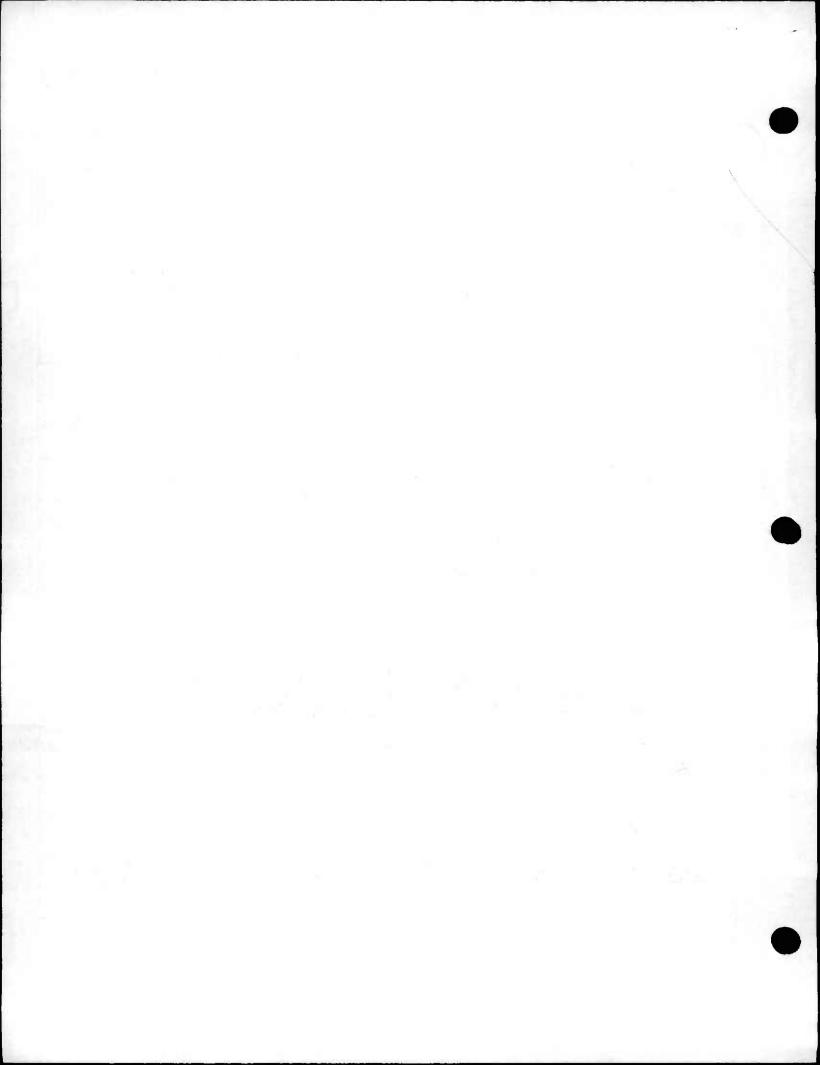
| | 1 - STATE REGISTRAR | CERTIFIC | CATE OF DEATH | REG. NO. | | |
|---------------|--|---|---|--|--------------------------|--|
| 1 | 1. OECEOENT'S NAME (First, Middle, Last) | Brown | | 2. DATE OF OEATH DAY | 7 / 9 O | 3. TIME OF OEATH |
| 1 | 4. SOCIAL SECURITY NUMBER S. SEX 216-44-9798 1 Mm 2 | 6. AGE (In yrs. lest birthdey) B 3 YRs. | F UNDER t YEAR IF UNDER 24 HRS. ONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTH Count Mar | yland//// |
| TOR | 90. FACILITY NAME (If not institution, give street and num SYKES U 11 & Elder RESIDENCE OF DECEDENT | care Center | SYKESUITE | ATH / | Sc. COUNTY OF D | |
| DIRECTOR | 100. STATE 10b. COUNTY CARROC | | TOWN OR LOCATION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER 7309 Second Ave 11. MARITAL STATUS 12. WAS DI | CEOENT EVER IN U.S. ARMED | 2/78 | 4 | 10g. CITIZEN OF 1 | A |
| B | 1 Never Merried 2 Merried FORCE IF YES, | GIVE WAR OR OATES | 13. WAS OECENDENT OF HISPAN If yes, specify Cuben, Mexics 1 YES 2 NO Specify | n, Puerto Rican, atc.) | Blac Spec | E-American Indian, k, White, atc. |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) College (1 | 16a. DECEDENT'S U: (Give kind of wo life. Do NOT use | SUAL OCCUPATION rk done during most of working retired.) | 186. KIND OF BUSI | Va val | lorent drown (|
| | 17. FATHER'S NAME (First, Middle, Last) BEAGARTHUBY BY KINGLE | JK/ | 18. MOTHER'S NA | ME (First, Middle, Maiden S | umame) | / |
| TO BE | 190. INFORMANT'S NAME (Type/Print) | 19b. MAILING A | Luce Crest | Route Number, City or Town, | | 5100/21461 |
| | 20a METHOD OF DISPOSITION 1- Burlel 2 Cremation 3 Hemoval from 5 4 Donellon S Other (Specify) | 206. PLACE OF DISPOSIT | Name of cemetery, crematory or | | ATION — City of TO | 11.01110 |
| | 21. BIOLATINE OF THE PRINCE LICENSEE | aylor | 22, NAME AND ADDRESS OF FA | | upe/ | 27401/ |
| | 23. PART I. Entar tha diseasea, or complication shock, or heart failure. List only of | ns that caused the death. Do no na causa on each line. | t antar tha moda of dying, auc | h aa cardiac or reapin | atory arrest, | Approximata interval Between |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) | SACOURAGE OF SOUR TO (OR AS A CONSEQUENCE OF) | rosist Cy | 45 | | Onset and Death |
| NOI | Sequentially list conditions 6 b. A3 | DUE TO (OR AS A CONSEQUENCE OF) | | S20 14 | 40 240 3 | |
| CERTIFICATION | cause. Entar UNDERLYING CAUSE (Disease or Injury | DUE TO (OR AS A CONSEQUENCE OF) | negeaven | oris of | Alone | refe |
| | PART ii. Other significant conditions contribu | ting to death but not resulting in | the underlying cause given in | | | b. WERE AUTOPSY FINDINGS |
| MEDICAL | | | | PERFORM | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Ä. | | | 7 | | | 1 TES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | At : | 28. PLACE OF DEATH (CA | eck only one) | | |
| IXSI | 1 U YES 2 (I) NO 1 Input | ent 2 ER/Oulpatient 3 DOA | Nursing Home S - Residence | | | |
| | 1 Natural 5 Pending | DATE OF INJURY Month, Day, Year) 28b. TIME INJU | | 28d. DEŞCRIBE HOW IN | JURY OCCURED | |
| TED BY | 3 Sulcide 280. I | PLACE OF INJURY — All home, farm, at building, atc. (Specify) | reet, factory, office | 28f. LOCATION (Street ar City or Town, State) | nd Number or Rural | Route Number, |
| COMPLETED | const. | best of my knowledge, death occurred | | | | a) and manner se stated. |
| BE C | 296. SIGNATURE AND TITLE OF CENTIFIER | 2 | 28c, LICENSE NU | MBER | 29d. DATE SIGNE | O (Month, Day, Year) |
| 2 | 30. NAW AND ADDRESS OF PERSON WHO COMPLET | ED CALICE OF SEATH STEM OF SEA | Delegal Delegal | THE | 11/2 | 7.1-023 |
| - 1 | 30. NAME AND ADDRESS OF PERSON WHO COMPLET | ED CAUSE OF CEATH (ITEM 27) (1998, 1 | rnn) | | | |
| | JULIAN W | REED M.B | | | | |

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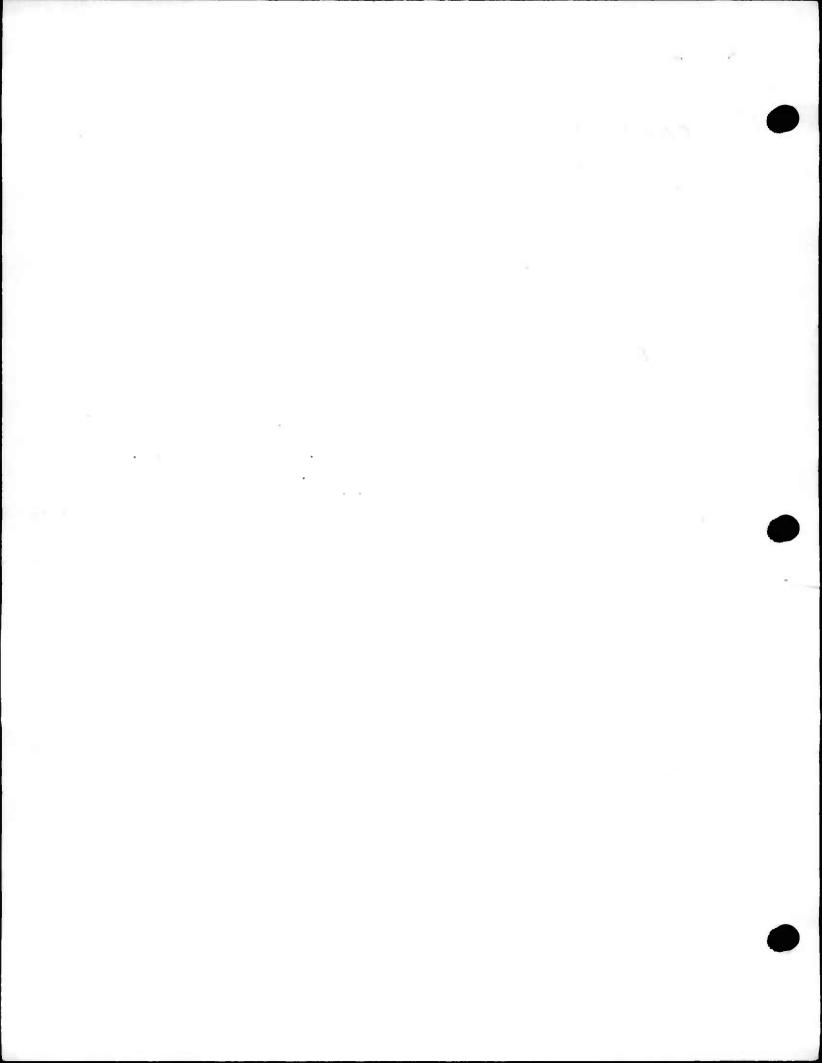
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| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the f | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical ex | ı |
| | | | | | |

| | 1 - STATE REGISTRAR | STATE OF MARYL | | | HEALTH AND I | MENTAL HYGIEN REG. NO. | E 36 | 1 34299 | | | |
|-----------------|---|--|-------------------------|--------------------|--|--|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) RICHARD W. B | RICHARD W. | ALLACE | BOWLI | 1G | 2. DATE OF DEATH | v vear 04 90 | 3. TIME OF DEATH 3:40 P M | | | |
| N | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | HPLACE (State or Foreign | | | |
| \mathcal{A} | 215-40-4939 | 1X M 2 🗆 F | 79 YRS. | MONTHS DAY | HOURE MIN. | (Month, Day, Year) 6/26/11 | | | | | |
| | Se. FACILITY NAME (If not institution, give st | reet and number) | | 9b. CITY, TOW | N OR LOCATION OF DE | | 9c. COUNTY OF | | | | |
| 8 | Charles County N | ursing Home | | La 1 | es | | | | | | |
| ַל | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | Y, TOWN OR LO | | | 0 | 10d. INSIDE CITY | | | |
| DIRECTOR | THE P. LEWIS CO., LANSING, MICH. 49, 129, 129, 129, 129, 129, 129, 129, 12 | ARLES | | a Plat | | | | LIMITS? | | | |
| | 10e. STREET AND NUMBER | | | a riai | 101. ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | | |
| FUNERAL | 24 U. S. 301 S | South | | | 206 | 46 | II S | Δ | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | | | ECENDENT OF HISPAN | IC ORIGIN? (Specify Yes | or No.— 14. RAC | E — American Indian, | | | |
| BY | 1 Never Married 2 Merried 3 Widowed 4 Olvorced | IF YES, GIVE WAR OR D | | | specify Cuben, Mexica ES 2 X NO Specify | | Spec | offy: | | | |
| | 15. DECEDENT'S EDUC | CATION | 16a. DECEDENT'S | LUSUAL OCCUP | TION | 165 KIND OF BUI | SINESS/INDUSTRY | White | | | |
| ₩ I | (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) | | work done during | | Section 541 Decision | | Station | | | |
| 릴 | 12 | | Powder | Facto | rv Make: | r U. S. (| | | | | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | | | | | |
| BE | Frank O'Neil B | owling | | | Nelli | e Mae Bra | shier | | | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | | | | |
| | Ethel O. Bowli | | | | South, | La Plata | CATION — City or T | land 20646 | | | |
| | 20a METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remo 4 Donatton 5 Other (Specify) | wat from State | other place) | | ial Gard | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | IIIIILLY | 22. NAME | AND ADDRESS OF FA | CILITY | | Maryland | | | |
| - 1 | + Wilnet | 10 tan | word | | | eral Home | | 0.5.6.5 | | | |
| | 23. PART I. Enter the diseeses, or c | omplications that cause | ed the deeth. Do | La F | node of dying, auc | aryland | ZU046- | Approximate | | | |
| | ahock, or heart fellure. I iMMEDIATE CAUSE (Final | List only one cause on a | sech line. | | | | | interval Between Onset and Deeth | | | |
| | disease or condition resulting in deeth) | Pneu | mo | ni | ~ " | | | İ | | | |
| Í | Total till g ill addity | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | | |
| Z | Sequentially list conditions, | sep | sis | 51 | | | | | | | |
| HILFICATION | if any, leading to immediate cause. Enter UNDERLYING | OUE TO JOR AS | A CONSEQUENCE O | W.T. | | | | i l | | | |
| 밀 | CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE O | F): | | | | | | | |
| | resulting in death) LAST | | | | | | | 2 | | | |
| | PART II. Other eignificent conditions | contributing to death | but not resulting | in the underly | ing cause given in | Part i. 24e, WAS AN | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS | | | |
| S S | arteriorde | usià, C | eld (1) | JAmi | the lift | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE | | | |
| | Kempleare | a. Herrer | tenni | n) an | remia | 1 TYES 2 | NO | OF DEATH? | | | |
| PHYSICIAN: MEDI | secruse d | usanter | . Ho Red | Lt chai | let lend | Ave | | 1 123 2 10 | | | |
| N N | 25. WAS CASE REPERRED TO MEDICAL EXAMINER? | | | | PLACE OF DEATH (Ch | eck only one) | | | | | |
| L SI | 1 TYES 2-12 NO | HOSPITAL: 1 Inpatient 2 ER/Out | tpatient 3 DOA | OTHER: | ome 5 🗆 Residence | 6 🗆 Other (Specify) | | | | | |
| ᇤ | 27. MANNER OF DEATH 1 Natural 6 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 26b. TII | ME OF 28c. | INJURY AT WORK? | 28d. DEŞCRIBE HOW I | NJURY OCCURED | | | | |
| B | 2 Acctdent Investigation | OR - DI ACE OF IN HIS | W 41 hard 4 mm | | YES 2 NO | | | | | | |
| ED | 3 Suicide a Could not be 4 Homicide determined | 26a. PLACE OF INJUR building, etc. (Spe | ecify) | street, rectory, o | mice | 26f. LOCATION (Street City or Town, State) | | Route Number, | | | |
| COMPLET | 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the heat of my hoo | wieden deeth engue | and at the time of | | | 7. C. S. S. S. S. S. S. S. S. S. S. S. S. S. | | | | |
| M N | const | CIAN: To the best of my known. R: On the basic of examination | | | | | | (e) end menner as stated. | | | |
| | SIGNATURE AND TITLE OF CERTIFIER | | -1 1 | | 29c. LICENSE NUI | | | D (Month, Day, Year) | | | |
| BE | tuse for | Schells | hMI |) | 1008 | 370 | ► 12 J | 14/90 | | | |
| 27 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF D | EATH (ITEM 27) (Typ | a, Print) | 1 1/2 | | , | /// | | | |
| | | | | | + | | | | | | |
| | 31. DATE FILED (Month, Day, Year) | 32. BEGISTRAB'S SIG | NATURE TANDER | | | | | | | | |
| | DECO 30 | June partus | | | | | | DHMH-16 Rev 1/89 | | | |



| en- | | | 1 - STATE REGISTRAR | STATE OF I | MARYL | AND / DEPAR Certif | | | | | IENTAL | REG. NO. | | | |
|---|--|---------------|---|--|----------------------------|--|-----------------|--------------|--------------------|------------|--------------|------------------------------------|-------------|---------------|---|
| | | 1 | 1. DECEDENT'S NAME (First, Middle, Last | | | | | | | | 2. DATE O | | | YEAR | TIME OF DEATH |
| | (P | | Charles, BK | S. SEX | A AGE (| in yrs. lest birthdey) | IF UNDER 1 | VEAD | IF UNDER | 24 MDG | Nou | | | 70 | MCE (State or Foreign |
| / | | | 097-16-7167 | -/ - | | 83 yrs. | | DAYS | HOURS | MIN. | (Month, | Day, Year) | / | Country) | MD |
| h | should | | 9e. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, | TOWN O | R LOCATIO | ON OF DEA | ATH . | | 9c. COUN | TY OF DEAT | н |
| 5 | S. W. P. | TOH | FAIISTON (JEN | JERAL F | tosp | ital | FAL | 50 | , (n | N | nd_ | | HAS | FOR | <u>d</u> |
| | ages 1 | DIRECTOR | 10a. STATE 10b. COUN | | | 1 | TY, TOWN OF | | ION | | | | | 10 | d. INSIDE CITY LIMITS? |
| | permit. Pages | | MD Ha | rford | | Al | berde | _ | ZIP CODE | | | | 100 CITIZ | | T COUNTRY? |
| | ist | FUNERAL | 1529 Meadowcres | t Ct. | | | | | 210 | | | | 109. 01112 | USA | |
| AND 21203-3146 the hospital or attending physician | burial-transit | FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDED FORCES? | 1 YES | 2 X NO | 11 | yes, spe | cify Cube | n, Mexicen | , Puerto Al | (Specify Yea can, etc.) | or No- | Black, W | American Indien, hite, atc. |
| 21203-3146 tall or attending place | the b | ВУ | 3 Widowed 4 Divorced | IF YES, GIVE | WAR OR DA | ATES | 1 | ☐ YES | 2 (X NO | Specify: | : | | | Specify: | Black |
| 203 | use as | TED | 15. DECEDENT'S ED (Specify only highest gra | de completed) | | 18e. DECEDENT'S (Give kind of life. Do NOT u | work done di | CUPATIO | ON st of workin | ng . | 16b. | KIND OF BUS | INESS/IND | USTRY | |
| 21 Soital o | ned for | IPLE | Elementary/Secondery (0-12) | College (1-4 or 5 | i+) | horse | | ner | | | | Racir | าต | | |
| ANE PER PER PER PER PER PER PER PER PER PE | detached once. | COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | iddle, Maiden | | | |
| RYL We by | ould be | BE | 19a. INFORMANT'S NAME (Type/Print) | | | 196 MAII IN | C ADDRESS | (Streat a | | | Bro | W N or, City or Town | e State 7/o | Codel | |
| MAI | e 5 should notified | 2 | Monroe Brown | | | | | | | | | deen. | | | |
| Ë, | funeral director, page xaminer must be | | 20e. METHOD OF DISPOSITION 1 CX Burlel 2 Cremation 3 Re | movel from State | | other place) | SITION (Nan | ne of cen | netery, cren | natory or | | 20c. LO | CATION C | City or Town, | State |
| MO Me Mo Me | direct | | 4 Donation 5 Other (Specify) | (CENSER') | y | Griffit | AUMF | IAME AN | EM. | SS OF FAC | CILITY | <u> Elk</u> | cton. | Md. | |
| BALTIMORE, MARYLAND after death. Page 6 may be retained by the hosp | e funeral die II. examiner | | * WeelVle | Mars | // | | An P | rnol .O.B | d W. | Bea 188 | rd Fi | uneral e de G | l Serv | vice . MD | |
| 45 | d in by the or removal. medical e | | 23. PART I. Enter the diseases, o shock, or heert failure | r compilcations th | et caused | d the death. Do | not enter | tha mo | da of dyl | ing, such | ss cerdi | ac or respl | retory srn | eat, | Approximate Interval Between |
| Sallon St. | ine in | | IMMEDIATE CAUSE (Final disesse or condition | , | | | 4 | A 15 | | 000 | H A /2 | ,10. | | | Onset and Death |
| 6, | completely fille ial, cremation, event, the | | resulting in dasth) | a | | R CINO | | Or | 1 | · Ch) | 1814 | 03 | | | 6Menthis |
| 13146, | | N | Sequentially list conditions, | b | | | | | | | | | | | |
| X | cian for t | CERTIFICATION | if any, lasding to immediata cause. Enter UNDERLYING | DUE TO | O (OR AS A | CONSEQUENCE (| OF): | | | | | | | | |
| O. BC | ing phy giene p | TE | CAUSE (Disease or Injury that initiated events | DUE TO | O (OR AS A | CONSEQUENCE (| OF): | | | | | | | | |
| ₽. ₽ | 8 T 6 | CER | resulting in death) LAST | d | | | | | | | | | | | |
| S a | od M | | PART ii. Other significant conditi | ons contributing to | o death b | out not resulting | in the un | derlying | g ceuse : | given in | | 24a. WAS AN PERFOR | MED? | A | ERE AUTOPSY FINDINGS (AILABLE PRIOR TO |
| CORD ires that | | MEDICAL | - | | | | | | | | - | 1 TES 2 | NO | O | OMPLETION OF CAUSE F DEATH? |
| | las been sign Dept. of Hea 23 shows | | | | | | | | | | - | | | ' | YES 2 NO |
| VITAL | State Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Che | ock only one |) | | | |
| - KICIAN | certificate the State | HYS | 1 YES 2 NO 27. MANNER OF DEATH | 28e. DATE C | OF INJURY | patient 3 DOA | ME OF | 28c. INJ | URY AT | esidence | 8 Other | (Specify) | NJURY OCC | CURED | |
| FO P | R. After this or death with | ВУ Р | 1 Natural 5 Pending 2 Accident Investigatio | | Day, Year) | III. | M | | YES 2 | NO | | | | | |
| DIVISION OF VITAL | DIRECTOR: After hours after death | | 3 Suicide 8 Could not b 4 Homicide determined | 28e. PLACE building | OF INJURY g, etc. (Spec | f — At home, farm. cify) | , atreat, fecto | ory, offic | • | | | ATION (Street a or Town, State) | | or Aurel Aou | te Number, |
| DI GOTTAL DE | TO THE FUNERAL DIRECT TO THE FUNERAL DIRECT De filed within 72 hours a IMPORTANT: If Item 2 | COMPLETED | condent of my | YSICIAN: To the best of NER: On the basic of | | | | | | | | | | | nd menner as stated. |
| I STIGOOD SAT OF | THE FU TO THE FU THE THE FU THE THE FU THE THE FU THE FU THE FU THE FU THE FU THE FU THE FU THE FU THE FU T | BE | 296. SIGNATURE AND TITLE OF CENTRE | u M | - | | | | 29c LIC | ENSE NUN | BER | | 29d, DATI | | lonth, Day, Year) |
| | | 5 | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CA | | 433 G71 | | ST. | HA | 1RE | DEC | TRACE | 5 . M | 1) 21 | 078 |
| | | | DEC 05 90 | 32. REGISTA | RAR'S SIGN | | | | | | | | | | |



FOR STATE

BALTIMORE, MARYLAND 21203-3146

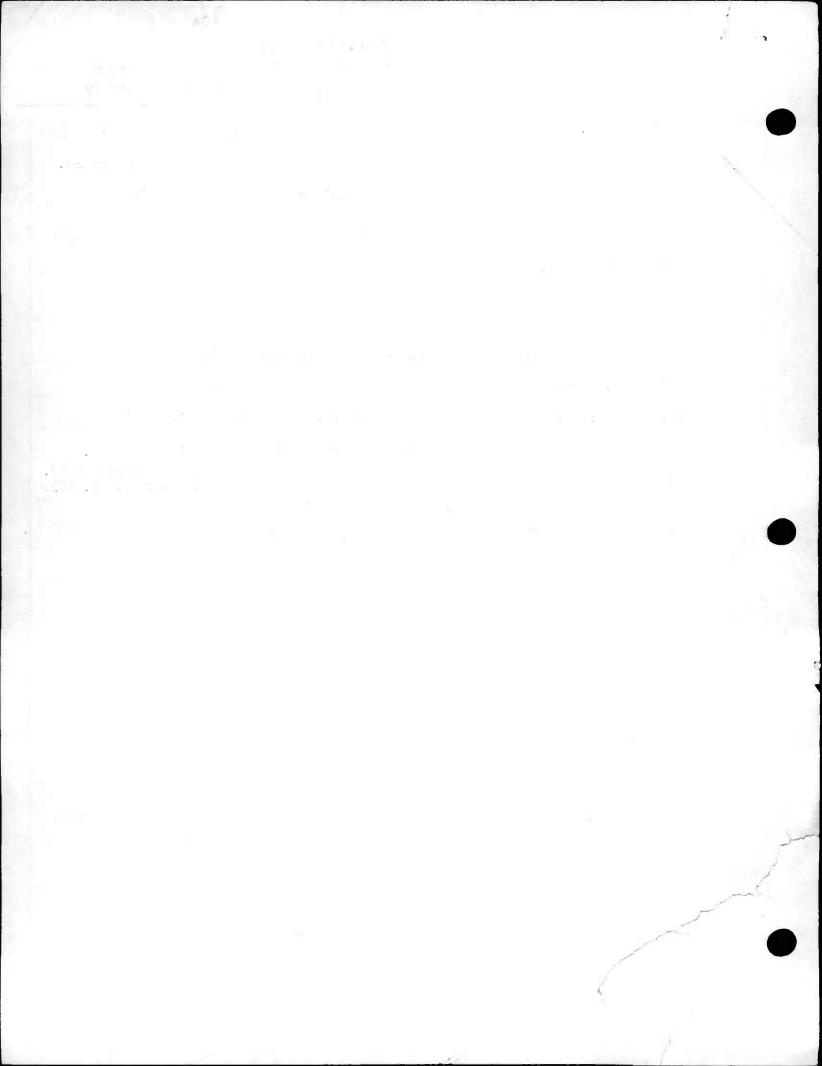
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

3430 90

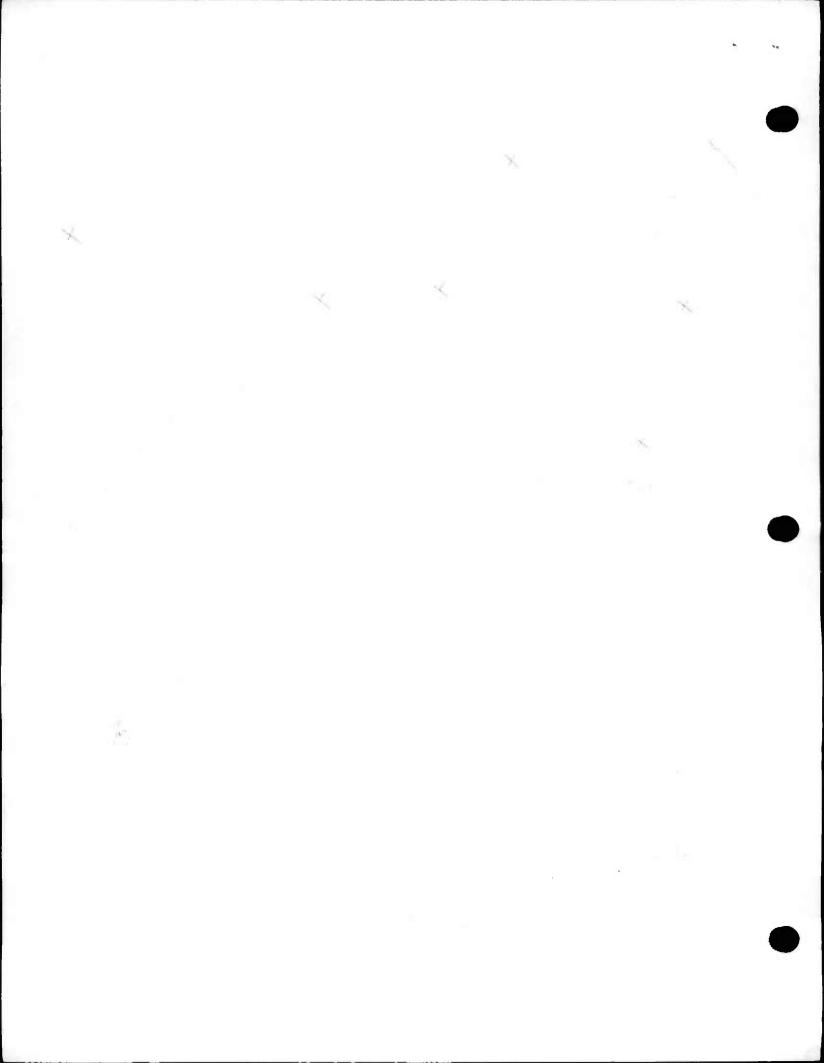
| 1. DECEDENT'S NAME (First, Middle, Las | 10 | 2 | 2111 | 7 8 0 | 5 / BOAT | É GE CEATHS" * | | 3. TIME OF DEATH | | | | | | |
|---|--|---|---|---|--|--|---------------------------|-----------------------|--|--|--|--|--|--|
| RICHARD W. | BRUCKMAN | | | 7. | Nov | 11 29,199 | O YEAR | 4531 | | | | | | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AG | | IF UNDER 1 YEAR | | HRS. 7. DAT | E OF BIRTH | 8. BIR | THPLACE (State or For | | | | | | |
| 212-16-6831 | 1 € M 2 □ F 7 | O YRS. | MONTHS DAYS | HOURS | | y 28,192 | | coona, Pa | | | | | | |
| 9a. FACILITY NAME (If not institution, give | e street and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | | | | |
| Sinai Hospit | tal | | Ва | Ltimore | 2 | | Cit | У | | | | | | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COU | NTY | 10c, CITY. | TOWN OR LOC | ATION | | | | 10d, INSIDE CITY | | | | | | |
| Sinai Hospit RESIDENCE OF DECEDENT 10a. STATE 10b. COUN Md. | Baltimore | | | s Mills | , | | | LIMITS? | | | | | | |
| | Bartimore | | | 101. ZIP CODE | • | 10 | g. CITIZEN O | F WHAT COUNTRY? | | | | | | |
| 10c. STREET AND NUMBER 2912 Walnut A 11. Marital Status | Ave. | | | 2111 | 7 | | | USA | | | | | | |
| 11. MARITAL STATUS | 12. WAS DECEOENT EVER | IN U.S. ARMED | | ECENDENT OF | HISPANIC ORIG | IN? (Specify Yea or I | 10- 14. R/ | CE — American India | | | | | | |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YE | DATES | | specify Cuban, ES 2 NO | Mexican, Puarte Specify: | Rican, etc.) | Sp | ack, White, etc. | | | | | | |
| · · · · · · · · · · · · · · · · · · · | PUGATION | 16a. DECEDENT'S U | | | | | | Mite | | | | | | |
| (Specify only highest gra | Bb. KIND OF BUSINE | SS/INDUSTRY | | | | | | | | | | | | |
| | 0 | D-14 | | | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | Yrs. Colleg | 4 Accum | Lant I | | State | POIICE Middle, Maiden Sum | ame) | | | | | | | |
| John E. Bru | ıckman | | | 5 File 9 S File 5 | dna Lai | | | | | | | | | |
| 100 INFORMANT'S NAME (Topo/Print) | | 19b. MAILING | ADDRESS (Stree | | | mber, City or Town, St | ate. Zip Code) | | | | | | | |
| Mrs. Velma M. Bu | ıckman | | | | | ills, Md | | 7 | | | | | | |
| 20a. METHOD OF DISPOSITION | 2 | 0b. PLACE OF OISPOSI | | | | | ON City or | | | | | | | |
| V Burial 2 □ Cremation 3 □ Re 4 □ Donation 8 □ Other (Specify) | nksburg, Md. | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE | ANO ADDRESS | ardens | | | erstown F | | | | | | | | |
| Eline Funeral Home Reisterstown. 23. PART 1. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardisc or respiratory errest, | | | | | | | | | | | | | | |
| Sequentially list conditions, if smy, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | | | |
| that initiated events resulting in death) LAST | d. | A CONSEQUENCE OF) |): | | | | | | | | | | | |
| | ions contributing to death | but not resulting in | the underly | ing cause gh | ven in Part I. | 24a. WAS AN AUT | | 24b. WERE AUTOPSY FIR | | | | | | |
| PART II. Other significant condition | Conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO NO NO NOTE: THE PROPERTY OF THE PROPERT | | | | | | | | | | | | | |
| E | | | | | | al . | | | | | | | | |
| Σ | | | 26. | PLACE OF DEA | NTH (Check only | one) | | | | | | | | |
| E . | HOSPITAL: | | OTHER: | eran o a succes | | Million St. St. | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 ER/O 26e. DATE OF INJUR (Month, Day, Year | rtpatient 3 DOA 28b, TIME | OTHER: 4 Nursing H | eran o a succes | dence 8 🗆 Ott | Million St. St. | RY OCCURED | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not 1 determined | 26a. DATE OF INJUR (Month, Day, Year 26a. PLACE OF INJUR 26b. PLACE OF INJUR dilding, etc. (S | y 28b. TIME INJU | OTHER: 4 Nursing H OF 28c. JRY 1 | ome 8 Resi | dence 8 | her (Specify) | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide 6 Could not 1 determined 4 Homicide 6 Could not 2 determined 29a. CERTIFIER 1 CERTIFYING PH (Check only one) 2 MEDICAL EXAM | 28a. DATE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR (Month, Day, Year 28a. PLACE OF INJUR dilding, etc. (S) YSICIAN: To the best of my kn INER: On the basis of examina | At home, farm, at overledge, death occurred | OTHER: 4 Nursing H OF 28c. JRY M 1 [treet, factory, or | NJURY AT NORK? YES 2 fice site and place, a | dence 8 Oti 26d. D NO 28f. LC Gr and due to the c d at the time, da | her (Specify) ESCRIBE HOW INJUI CATION (Street and I by or Town, State) cause(s) and manner ate end place, end du | Number or Rur as stated. | al Route Number, | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not 1 determined | 28e. DATE OF INJUR (Month, Day, Year be 28e. PLACE OF INJUR 28e. PLACE OF INJUR dilding, etc. (S) YSICIAN: To the best of my kn INER: On the basis of examina | PATH (ITEM 27) (Type | OTHER: 4 Nursing H OF 28c. RY M 1 [Irreet, factory, or d at the time, d h, in my opinion | NJURY AT NORK? YES 2 Ifice arte and place, a , death occured | dence 8 Ott 26d, D NO 28f, LC | her (Specify) ESCRIBE HOW INJUI DICATION (Street and in yor Town, State) Esuse(s) and manner at and place, end du | as stated. Je to the caus | al Route Number, | | | | | | |

DHMH-16 Rev 1/89



| BALTIMORE, MARYLAND 21203-3146 | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by the hospital or attending physic | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the buria |
|--|--|--|
| | ecuted within 2 - ours aft | and completely filled in by |
| ECORDS, P.O. BOX | quires that the death certificate be e | n signed by the attending physician |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | L OR ATTENDING PHYSICIAN: The law re | DIRECTOR: After this certificate has bee |

| | FOR STATE REGISTRAR | | STATE OF M | | | | F HEALTH AND | MENTA | L HYGIEN REG. NO. | _ | | | |
|-----------|---|--|-----------------------------|--|-------------------------------------|--------------|---------------------------------|---|-------------------------------------|-----------------|--------------|--|-----------|
| | 1. DECEDENT'S NAME (First, A | | 1 a | _ | | | | 2. DATE | | | AR | TIME OF DE | |
| , , | 4. SOCIAL SECURITY NUMBE | | \$EX | 6. AGE (In yrs. | last birthday) # | UNDER 1 YE | AR IF UNDER 24 HRS. | | OF BIRTH | 6. 6 | BIRTHPL | 8:30 ACE (State or | |
| | 214-20-1835 | | □ M 2 (F | 72 | YRS. | NTHS DA | 77 33-31: 1-23 | 02- | m, Dey, Year) 12–191 | 8 W | est | Virgi | nia |
| R | 90. FACILITY NAME (If not inst Countryside F | | | Alberi 18111 F | | | wn or location of Di Ipstead | EATH | | ec. county | of deat | | |
| 2 | RESIDENCE OF DECE | DENT 10b. COUNTY | | | 10c. CITY, T | OWN OR L | OCATION | | | | 10 | id, INSIDE CI | TY |
| DIRECTOR | Md. | Carı | roll | | | ineb | | | | | | LIMITS? | |
| ERAL | 100. STREET AND NUMBER 5140 Schalk | Road # | 1 | | | | 101. ZIP CODE 21088 | | | 10g. CITIZEN | | T COUNTRY | ? |
| FUNE | 11. MARITAL STATUS | 12 | . WAS DECEDENT FORCES? 1 | EVER IN U.S. | ARMED | | DECENDENT OF HISPA | ANIC ORIGIN? (Specify Yee or No. 14. RACE - | | | American In- | dlen, | |
| | 1 Never Merried 2 M 3 Wildowed 4 Divorce | 1532311 | IF YES, GIVE W | | · · · | | YES 2 O NO Specifi | | rricen, etc.) | | Specify: | White | |
| | 15. DECEI (Specify only i | DENT'S EDUCATION OF THE PROPERTY OF THE PROPER | ON opleted) | | DECEDENT'S US (Give kind of work | done durin | PATION g most of working | 18 | b. KIND OF BU | SINESS/INDUST | RY | | |
| COMPLET | Elementary/Secondery (0-1 8th grade | 2) C | ollege (1-4 or 5+ |) | Housew | | | | | | | | |
| 5 | 17. FATHER'S NAME (First, Mid Andrew Molda | | | | | | 16. MOTHER'S NA | | Middle, Malden Pfeif | | | | |
| H H | 190. INFORMANT'S NAME (Typ | | | | 19b. MAILING AC | DRESS (St | reet and Number or Rural | | | | fa) | | |
| 임 | Teresa Ann E | | | | | | Road #1, | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 Burlet 2 Cremetion 3 Removal from State Carroll Cremetory or other place) 4 Donation 5 Other (Specify) 20e. LOCATION — City or Carroll Cremation Services Hampstead, | | | | | | | | | | | | nd |
| | 21. SIGNATURE OF SUNERAL | | SEE 2 C | | | | E AND ADDRESS OF FA | | | Funera | - | - | |
| | > Stew | er T | U. E. | line |) | 934 | S. Main S | Stree | | | | | 74 |
| CATION | IMMEDIATE CAUSE (Fine disease or condition resulting in deeth) Sequentielly list condition if eny, leading to immediate. | e | | ~~ | SEQUENCE OF): SEQUENCE OF): | Lu | smoke | 100 | | | | | nd Death |
| CERTIFICA | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in deeth) LAST | | | | | | | | | | | | |
| MEDICAL | PART II. Other significen | | ontributing to | steri | | ٠ | dying cause given in | Part I. | 24a. WAS AN PERFOR 1 TYES 2 | RMED? | AA Ct | ERE AUTOPSY MILABLE PRIC OMPLETION O F DEATH? | OR TO |
| CIAN: | 25. WAS CASE REFERRED TO | | | | | | 6. PLACE OF DEATH (C | heck only | one) | _ | | | |
| S | EXAMINER? 1 YES 2 NO | | OSPITAL: | | 3 DOA 4 | _ | Home 5 - Reeldence | _ | | Board | | Home | |
| / PHY | 27. MANNER OF DEATH 1 Natural 5 P | | 28e. DATE OF (Month, D | ay, Year) | 28b. TIME O | Y | WORK? | 28d. Di | ESCRIBE HOW | INJURY OCCUR | 60 | | |
| TED BY | 3 Suicide 6 C | ould not be stermined | 28e. PLACE O building, | F INJURY — At etc. (Specify) | home, ferm, stre | et, lactory, | office | | CATION (Street y or Town, State) | end Number or I | Rurei Rou | te Number, | |
| COMPLET | 000) | | | | | | date end place, end du | | | | ouse(e) e | nd menner e | e stated. |
| BE | 29b. SIGNATURE AND TITLE | OF CERTIFIER | | | | | 29c. LICENSE NU | | | 29d. DATE SI | GNED (M | lonth, Day, Yes | nr) |
| 2 | 30. NAME AND ADDRESS OF | PERSON WHO C | OMPLETED CAUS | SE OF DEATH (| ITEM 27) (Type, Pr | Int) | D 33 | 974 | | // | / 30 | 7/40 | |
| | 31. DATE FILED (Month, Day,) | par) | Fina Ve | ASSIGNATION OF THE PARTY OF THE | mount | 4 | 450 | B | lackroc | ckRd | 1-1 | empste | ad. |
| | DEC 3 - '90 |) | ginavi | NIME OF | | | | | | | | | |
| | | | | | | | | | | | | ОНМН | 1-16 |



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| | | Pages |
| | | permit. |
| BALTIMORE, MARYLAND 21203-3146 | ifter death. Page 6 may be retained by the hospital or attending physician. | The funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2. |
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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within an usual references and the retained by the hospital of THE FINERAL DIRECTOR: After this certificate has been signed by the attention physician and completely filled in by the tuneral director, page 5 should be detached for be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

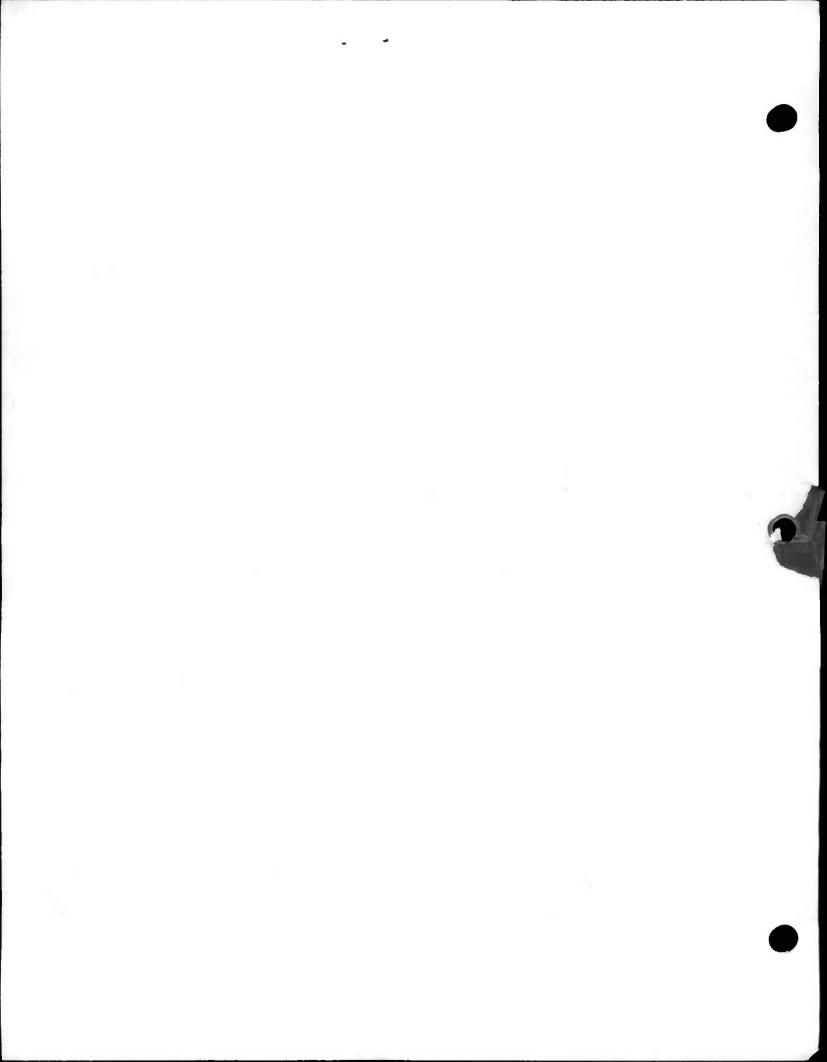
DIVISION OF VITAL RECORDS, P.O. BOX 131

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| SOURCE SAME POR MARKET NAME OF THE SAME OF THE STATE OF | 1 - FOR STATE REGISTRAR | E OF MARYLAND / DE | PARTMENT OF TIFICATE O | | MENTAL HYGIENE REG. NO. | | |
|--|--|---------------------------------|---------------------------|--------------------------|----------------------------|--------------------|------------------------|
| SOCIAL PROPERTY AND ADDRESS AN | Nilse | OLIT | III IOAI L O | DEATH | 2. DATE OF DEATH | 11.50 | 3. TIME OF DEATH |
| 215 - 16 - 0079 W = P 69 | LLOYD BARNES | BOYD BARNES Loyd Oscar Barnes | | | | | 8:05 P M |
| AND THE PROPERTY GENERAL HOSPITAL SECURITY OF BEATH OLNEY SECURITY COWN ON LOCATION OF BEATH MONTGOMERY SECURITY COWN ON LOCATION OF BEATH MONTGOMERY SECURITY COWN ON LOCATION SECURITY SE | | 141-25-25-11-25-25-25-2 | MONTHS DAY | | (Month, Day, Year) | Cour | |
| MONTGOMERY REBIDITION BETT OLD CONTROL B | 213 10 0017 | 07 | RS. | | | | |
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| MARLURAN HOWARD THE STORM HOW | MONTGOMERY GENERAL RESIDENCE OF DECEMENT | L HOSPITAL | 1 0 | TWEX | | 1101011 | JOHEN |
| 13.88 HAND LINE OF BUSINESS REPORT SUCCESS IN U.S., AMOUNT STATES AND AMERICAN STATES | | 10 | c. CITY, TOWN OR LO | CATION | | | |
| 11. MANTILL STATUS 12. MAD DECERDET EVER IN U.S. ANAE 11. MANTILL STATUS 12. MAD DECERDET STATUS IN U.S. ANAE 12. MAD DECERDET STATUS IN U.S. ANAE 12. MAD DECERDET STATUS IN U.S. ANAE 13. MAD DECERDET STATUS IN U.S. ANAE 14. MACE ANAE ANAE OF THE STATUS IN U.S. ANAE 15. MAD DECERDET STATUS IN U.S. ANAE 16. MACE ANAE OF THE STATUS IN U.S. ANAE 17. MAD DECERDET STATUS IN U.S. ANAE 18. MACHER STATUS IN U.S. ANAE (PART MAD STATUS IN U.S. ANAE ANAE ANAE OF THE STATUS IN U.S. ANAE ANAE ANAE OF THE STATUS IN U.S. ANAE ANAE ANAE OF THE STATUS IN U.S. ANAE ANAE ANAE OF THE STATUS IN U.S. ANAE ANAE ANAE ANAE ANAE ANAE ANAE ANA | | | Laurel | | | | - 4. |
| 11. MANTER STATUS New Processor 1 | | | 1 | | | • | |
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| Securities Sec | 1 Name Married 2 X Married FOR | ICES? 1 TYES 2 NO | If yes, | specify Cuban, Maxica | n, Puarto Rican, atc.) | | |
| Constructor you have a gradual grade completion Canpenter Ca | 3 Widowed 4 Divorcad | | | - | | | White |
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| The MOTHER'S NAME (First, Mission, Later) David Bathers | | a (1-4 or 5+) | | | | | Appecea |
| The Mallian Address (Street and Number or Paral Polate Number, Cory or Town, State 1138.3 Handling Road Laurel, Maryland 2072.3 | | Γαπρ | emer | 16. MOTHER'S NA | | | |
| The Mallian Address (Street and Number or Paral Polate Number, Cory or Town, State 1138.3 Handling Road Laurel, Maryland 2072.3 | David Barnes | | | Lettie. | Worell. | | |
| 38. PLACE OF DISPOSITION Name of camelary or 20c. LOCATION — Chy or Town, State 20c. DocaTiON — Chy or Town, State | | 19b. M/ | AILING ADDRESS (Stre | | | , Stata, Zip Code) | |
| 21. SIGNATURE PYRNERAL SERVICE LIGHNESSE 21. SIGNATURE PYRNERAL SERVICE LIGHNESSE 22. MARE AND ADDRESS OF SACILITY POUNDLAGS ON FUNDRAL Home, P.A. 313 Talbott Ave. Lawrel, Maryland 20707 23. PART I. Enter the diseases, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrent, shock, or hearf fallus. List only one cause on each line. IMMEDIATE CAUSE (Fined disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQ | Mary R. Barnes | 113 | 83 Hardir | ig Road | Laurel, Mo | ıryland | 20723 |
| 22. NAME AND ADDRESS OF FACILITY POUNDATED AS OF FACILITY POUNDATED AND A CONSEQUENCE OF: CONCORDING A CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): CONSEQUENCE OF): DUE TO (OR AS A C | 20a METHOD OF DISPOSITION 1-X Burial 2 Cremation 3 Removal from | 20b. PLACE OF I other place) | · | | | - | |
| 23. PART II. Enter the diseases, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Between Onset and Death shock, or heart fallure. List only one cause on each line. IMMEDIATE CAUSE (Finel diseases or condition resulting in deeth) DUE TO (OR AS A CONSECUENCE OF): USE TO (O | | Emmanu | | | | ggsville | e, Maryland |
| 23. PART II. Enter the diseases, of complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or heart fallule. List only one cause on each line. IMMEDIATE CAUSE (Fined diseases or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): OUT TO (OR AS A CONSEQUENCE OF): DUE TO (| 21. SIGNAL DREAT PONENAL SERVICE COLORSEE | 1/1/ | Dov | aldson Fu | neral Home, | P.A. | |
| Sequentially list conditions, leading to immediate course. Earth NUMERIAN CAUSE (Finel disease or condition resulting in deeth) Sequentially list conditions, leading to immediate course. Earth NUMERIAN CAUSE (Disease or Injury to Injur | Lebel At Hoyx | balling } | | | | | 20707 |
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| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) EXAMINER OF DEATH 1 Netural 5 Pending Investigation 3 Sulcida 6 Could not be detarmined Investigation, at City or Town, State) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29b. SIGNATUSE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | d | | | | | | + |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 Inpatiant 2 EN/Outpatiant 3 DOA 4 Nursing Homa 5 Realdence 8 Other (Specify) 27. MANNER OF 'DEATH 1 Natural 5 Pending Investigation 3 Sulcida 6 Could not be determined 28a. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 29a. CERTIFIER (Check only one) 29a. CERTIFIER Of the basis of my knowledge, dasth occurred at the time, date and place, and due to the cause(a) end menner as eteted. 29b. SIGNATULE AND TITLE OF CERTIFIER On the basis of axemination and/or investigation, in my opinion, dasth occurred at the time, date and place, and due to the cause(a) end menner as eteted. 29b. SIGNATULE AND TITLE OF CERTIFIER DATE OF DEATH (ITEM 22 (Type, Print)) 29c. LICENSE NUMBER DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) 29d. DATE SIGNED (Month, Day, Year) | PART II. Other algnificent conditions contri | // - /- / | A | lying ceuea givan in | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | The state of the s | | en, | 1 | 1 🗆 YES 2 | NO | |
| EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 DOA 4 Normal Homa 5 Realdence 8 Other (Specify) 28b. TIME OF 28c. INJURY 28d. DESCRIBE HOW INJURY OCCURED WORK? WORK? WORK? 1 YES 2 NO 28a. PLACE OF INJURY — At home, farm, street, factory, office 281. LOCATION (Street and Number or Rurel Route Number, City or Town, State) 29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(a) end menner as etated. 29b. SIGNATURE AND TITLE OF CERTIFIER — 29c. LICENSE NUMBER — 2 | Most likely 1 | refortatie (| ep lu | ry On | | ' | 1 🗆 YES 2 📆 NO |
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| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the beale of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) end menner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER D. 29c. LICENSE NUMBER D. 32417 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) RAHVU SILVARIAN STORY OF CERTIFIER D. 29c. LICENSE NUMBER D. 32417 29c. LICENSE NUMBER D. 32417 29c. LICENSE NUMBER D. 32417 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) 29d. DATE SIGNED (Month, Dev. Year) | Investigation | (Month, Day, Year) | INJURY M | | _ | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of my knowledge, dash occurred at the time, date and place, and due to the cause(a) end menner as atted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Ybar) 112 4 90 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20 (Type, Print)) RAHVU SILVATOR AND 10620 GORGIA AVE #2 18 18 18 18 18 18 18 18 18 18 18 18 18 | 28 Accident | | farm, street, factory, | office | 28f. LOCATION (Street a | and Number or Rur | ral Routa Number, |
| (Check only one) 2 MEDICAL EXAMINER: On the basis of my knowledge, datan occurred at the time, date and place, and due to the cause(a) and manner as stetad. 29b. SIGNATURE AND TITLE OF CERT FIRE 29c. LICENSE NUMBER D 32417 29d. DATE SIGNED (Month, Day, Year) 1127 127 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) RAHVU GILLOTRA MI) 10620 GRORGIA AVE#2) 8 SILVEY Sport MID 20902 | | bunding, and (openly) | | | ony or rown, oraco, | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER D 3 2 4 1 7 29d. DATE SIGNED (Month, Day, Year) 10 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) RAHVU (STILOTRA) 10 NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) 10 CORRESPONDED 10 CORRESPONDED 10 CORRESPONDED 10 CORRESPONDED 10 CORRESPONDED 10 CORRESPONDED 10 CORRESPONDED 11 CORRESPONDED 12 CORRESPONDED 13 CORRESPONDED 14 CORRESPONDED 15 CORRESPONDED 16 CORRESPONDED 17 CORRESPONDED 17 CORRESPONDED 18 CORRESPONDED | | the best of my knowledge, death | occurred at the time, | date and place, and du | a to the cause(a) end mer | nner ae atated. | |
| NOWM (MOVING D32417 11/27/90) 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Typo, Print) RAHUL GILOTRA M) 10620 GORGIA AVE#218 Silver Shiring WD 20902 | anal — | | | | | | |
| RAHUL GILOTRA MI) 10620 GORGIA AVE#218 MD 26902 | 296. SIGNATURE AND TITUE OF CERTIFIER | / | | 29c. LICENSE NU | MBER | 29d. DATE SIGN | NED (Month, Day, Year) |
| RAHUL GILOTRA MI) 10620 GORGIA AVE#218 MD 26902 | 10000 MONIE | | | D 524 | - <i>l</i> + | > /// | 47/90 |
| AN DATE FILED (March Day March | RAHUL GILOTRA MI) 10620 GORGIA AVE#218 MD 20902 | | | | | | |
| NOV 28 '90 Sicha Davidson-Pandole | 31. DATE FILED (Month, Day, Year) 32 | REGISTRAR'S SIGNATURE | | | | | |





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| 5 | | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF HI | | HYGIENE REG. NO. | 90 | 1 3 | 4304 |
|--|-----------------------------------|--|---|---|---|--|---|----------------|-------------------|--|
| | | 1. DECEOENT'S NAME (First, Middle, Last) Frances C. Beitle | France | C. Beitl | er | | DATE OF GEATH | | AR IO | e of death 30 P |
| | | 4. SOCIAL SECURITY NUMBER 214- 343-334 | 5. SEX 6. AGE (| In yrs. lest birthdey) \$\sigma_{2}\$ YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | Month, Day, Year) | Co | erthplace ountry) | (State or Foreign |
| | NO NO | 90. FACILITY NAME (If not institution, give s Howard County 6 | | | | R LOCATION OF DEATH | nO | 9c. COUNTY C | | |
| ← " | DIRECTOR | 100. STATE 10b. COUNT | e George | | Y, TOWN OR LOCATI | ON | | | L | NSIDE CITY IMITS? YES 2 NO |
| 46 physician. burial-transit permit. Pages | FUNERAL | 100. STREET AND NUMBER 400 OLD LINE AUG | | L | | ZIP COOE 0724 | | 10g. CITIZEN (| OF WNAT C | OUNTRY? |
| 03-3146 attending physician. se as the burial-trar | BY | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IP FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 🔀 NO | 13. WAS DECE If yes, spe | ENDENT OF HISPANIC Ocity Cuben, Mexicon, Pu 2 M NO Specify: | | | Black, White | nericen indien, e, etc. Thite |
| 212 Ital or I for u | PLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondery (0-12) | CATION completed) College (1-4 or 5+) | (Give kind of life. Do MOT u | usual occupation work done during mosse retired.) | N It of working | 166. KIND OF BUSI | ating | | |
| | ed at once. BE COMPL | | rray | | | 18. MOTHER'S NAME (A | lbaugh | | | |
| | TO B | 190. INFORMANT'S NAME (Type/Print) Zane W Beitler | | 400 0 | ld Line | Ave., Laur | el Md 20 | 724 | | |
| ALTIMORE, I death. Page 6 may be funeral director, page | 15 E | 20a. METHOO OF DISPOSITION 1 | noval from State | other place) | ine Park | | Balt | imore (| | |
| - | examiner | · Harry H | Witake | | Harry 4112 | H Witzke | Funeral l | llicot | t Cit | y |
| within medics at pletely filled in by cremation, or remi | event, the medical | 23. PART I. Enter the disasses, or ahock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on a | d tha death. Do ach lina. | varian | | cardiac or reapin | atory arrest, | 1.3 | Approximata Interval Between Onset and Death |
| . O. BOX 131 h certificate be execute inding physician and c Hygiene prior to buria | or other traumatic | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | ¢ | CONSEQUENCE C | · | | | | | |
| at the by the and Me | shows any injury, : MEDICAL CE | PART II. Other significant condition | na contributing to death b | out not resulting | In the underlying | g cause given in Pari | 24a. WAS AN / PERFORI | MED? | COMP OF DE | AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 NO |
| TAL RI The law re tte has bee ate Dept. c | SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PL | ACE OF DEATH (Check of | only one) | | | |
| | PHY | 1 YES 2 NO 27. MANNER OF DEATN 1 Natural 5 Pending Investigation | 1 € Inpatient 2 □ ER/Out | 26b. TII | 4 Nursing Hom- | e 5 Realdence 6 URY AT RK? /ES 2 NO | Other (Specify) d. DE\$CRIBE NOW IN | IJURY OCCURE | EO | |
| DIVISION OR ATTENDING P DIRECTOR: After thours after death | 2 2 | 2 Accident Investigation 3 Suicide 8 Could not be 4 Nomicide determined | 26e. PLACE OF INJURY building, etc. (Spe | f — At home, ferm, | street, factory, office | 281 | f. LOCATION (Street a City or Town, State) | nd Number or R | lural Route N | lumber, |
| DIS PORT | ANT: If item | CONSCIN ONLY | SICIAN: To the best of my know ER: On the beels of examination | | | | | | luse(a) and r | manner ee stated. |
| TO THE HOSPI TO THE FUNEF be filed within | TO BE COM | 29b. SIGNATURE AND TITLE OF CERTIFIE | dela | | | 29c. LICENSE NUMBER | 4. | 29d. DATE SA | SNED (Month | n, Day, Year) |
| 15 | - | 30. NAME AND A CAPTADA CA | · 3001 Sor | | | ST MD | -21230 | • | | |
| | | 31. OATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGN | NATURE 30 | Lehie David | ST MD | | | | |

| - | FOR STATE REGIS | |
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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | 0 | | | | DEATH | RE | G. NO. | | | | |
|--|--|---|---|--|---|---|---------------------------|--|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) ast BALZAND | | RAPHAEZ Middle | | d dle | 2. DATE OF DEATH MONTH OF 2 | | 9°EAR | 3. TIME OF DEATH | | | |
| | 4. SOCIAL SECURITY NUMBER 248-07-8738 | SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 NRS. 7. DATE OF BIRTH | | | | | RTH 2 ^(6ar) | 6. BIRTHPLACE (State or Foreign Country) Italy | | | | |
| O.B. | 9a. FACILITY NAME (If not institution, give st Greater Laurel Be | | ospital | | 9b. CITY, TOWN OR LOCATION OF DEATH Laurel 9c. COUNTY OF DEATH Prince George's | | | | | | | |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | |
| | Maryland Prince George's Laurel | | | | | | | | 1 TES 2 NO | | | |
| VERA | 100. STREET AND NUMBER 101. ZIP CODE 102229 Shadetree Lane 103. CITIZEN OF WHAT COULD USA | | | | | | | WHAT COOKINT? | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 💢 Married 3 Nidowed 4 Divorced | 12. WAS DECEDENT EV FORCES? 1 1 1 IF YES, GIVE WAR C | ER IN U.S. ARMED /ES 2 A NO OR DATES | | If yes, ape | ENDENT OF HISPAN city Cuben, Maxicer 2 NO Specify | , Puarto Rican, | ecify Yea or , atc.) | Ble | CE — American Indian, ack, Whita, stc. nite | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | | 18e, DECEDENT (Give kind o | 'S USUAL Of work done of use retired.) | CCUPATIO during mos | N t of working | 16b. KIND | OF BUSIN | ESS/INDUSTRY | | | |
| COMPLETED | Elementery/Secondery (0-12) | College (1-4 or 5+) | Print | | | | Ne | w Pap | er | | | |
| DS - SO | 17. FATHER'S NAME (First, Middle, Last) Peter Paul Balzan | 0 | | | | 18. MOTHER'S NAI | | Malden Sul Mulin | | | | |
| 90 | 19a. INFORMANT'S NAME (Type/Print) Eugenia B. Fritz | | | | | ee Lane, | | | | 8 | | |
| | 20s. METHOD OF DISPOSITION 1/1 Burial 2 Cremation 3 Remo | oval from State | 20b. PLACE OF DISP other place) St. Law | OSITION (Na | me of cem | etery cremetory or | | 20c. LOCA | ATION - City or Town, State relston S.C. | | | |
| | 3 SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | , , | 22. | Flec | k Funera | 1 Home | | | ND 00707 | | |
| | 23. PART I. Enter the diseasea, or cahock, or heart fallure. I IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | List only one ceuse of | notory | not enter | the mod | . 1 | as cardiac | | | Approximate intervel Between Onset and Death | | |
| RIIFICATION | disease or condition resulting in deeth) Due to or as a consequence of: Previous bulgitarial Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | | | |
| CERIFIC | CAUSE (Diseesa or injury that initieted events resulting in deeth) LAST | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | | | | |
| DICAL | PART II. Other significent condition | a contributing to dee | th but not resultin | g in the un | ndarlying | cause given in | Part I. 24a. | WAS AN AU | | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | | |
| ¥ | | | | | | | 1 | YES 2 |) NO | COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL | ACE OF DEATH (Che | eck only ona) | | | | | |
| 2 | EXAMINER? 1 YES 2 NO HOSPITAL: OTHER: 4 Nursing Homa 5 Realdance a Other (Specify) | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | | | | | | | | | | | | |
| ا د | 3 Suicide 8 Could not be detarmined | Suicide 8 Could not be 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) | | | | | | | al Routa Number, | | | |
| COMPLEIE | onol | CIAN: To the best of my i | | | | | | | | e(a) and manner as stated. | | |
| ᇤ | 29b. Biografiant (90) M.E. OF CERTIFIER | | | nh | | 29c. LICENSE NUM | | | | ED (Month, Day, Year) | | |
| 2 | 30, NAME AND ADDRESS OF PERSON WH | POMPLETED CAUSE O | F DEATH (ITEM 27) (7) | | 17 | Chon | N) | 0 / | aur | - IMA | | |
| | 31. DATE FILED (Month/Day, Year) NOV 2 7 90 Suhia Davidson-Randelle | | | | | | | | | 20707 | | |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

DHMH-16 Rav 1/69

3. TIME OF DEATH

Maryland

8. BIRTHPLACE (State or Foreign

DAY

28d, DESCRIBE HOW INJURY OCCURED

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29d. DATE SIGNED (Month. Day Year)

22

7. DATE OF BIRTH

(Month, Day, Year, 09/13/03

40

Laurel,

1. OECEDENT'S NAME (First, Middle, Lest)

Naomi Burnett

1 M 2 X F

28e. DATE OF INJURY (Month, Day, Year)

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAN'S SIGNATURE
JUNA DAMASON

5 SEY

Margaret

4. SOCIAL SECURITY NUMBER

577-42-6752

IF UNDER 1 YEAR

DAYS

IF UNDER 24 HRS.

HOURS

8. AGE (In yrs. last birthday)

87

VRS

28b. TIME OF

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated.

28e. PLACE OF INJURY — Al home, farm, street, factory, office building, etc. (Specify)

28c. INJURY AT WORK?

2 🗌 NO

29c. LICENSE NUMBER

1 YES

2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occured at the time, date end piece, end due to the ceuse(e) end menner ee stated.

Cherry

be retained by the hospital or attending physicianing 5 should be detached for use as the burial-time.

funeral director, page 5 should

by the attending physician and completely filled in by the and Mental Hygiene prior to burial, cremation, or removal.

death. Page 6 may

once.

notified at

must be

examiner

other traumatic event, the medical

6 injury,

shows any

Item certificate h

6

60

28 tem

BY

COMPLETED

BE

2

27. MANNER OF DEATH

5 Pending

a Could not be determined

anglille

1 Natural

2 Accident

3 Suicide

4 Homicide

Health a

has been s Dept. of H 23

this cu marked,

After 1

DIRECTOR: A

FUNERAL (within 72 h Ξ

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: II

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CE | RTIFIC | CATE | OF | DEATH | | REG. NO. | | | |
|-------------|--|-------------------------------------|--|--------------------|-----------------------|------------|---|-----------------|---------------------------------|---|------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | OF DEATN | | | 3. TIME OF DEATH |
| | Frank A | Amos | Be | nne | tt | | | Dec | 7 7 | | YEAR | 1415 M |
| | | | NGE (In yra. last I | | IF UNDER 1 | YEAR | IF UNDER 24 HRS. | 7. DATE | OF BIRTN | Ĩ | 8. BIRTI | NPLACE (State or Foreign |
| | 220-44-3242 | № 2 F | 91 | YRS. | NONTHS | DAYS | HOURS MIN. | Dec | 10, | 1898 | Mar | yland |
| | 9a. FACILITY NAME (If not institution, give street a | and number) | | - 1 | 9b. CITY. | TOWN O | R LOCATION OF DE | | . 107 | | NTY OF D | 75 |
| DIRECTOR | Calvert Memoria | | ital | | | | e Frede | | k | 220111 | alve | |
| 5 | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | 10c. CITY, | TOWN OF | | | | | | | |
| | | | | | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | Maryland Calvert 10. STREET AND NUMBER | , | | Port | Rep | | | | | | | 1 TES 2 NO |
| FUNERAL | | | | | | | ZIP CODE | | | 10g. CITI | ZEN OF | WHAT COUNTRY? |
| | 16 Elder Road | | | _ | | | 0676 | | | | | States |
| 2 | 11. MARITAL STATUS 12. 1 Never Married 2 Married | FORCES? 1 TY | YES 2 NO | ED | 13. W | AS DECI | ENDENT OF NISPAN city Cuban, Mexica | IIC ORIGIN | i? (Specify Yea Rican, atc.) | or No- | 14. RAC Blac | E — American Indian, k, White, etc. |
| 2 | | IF YES, GIVE WAR (| OR DATES | | | | 2 NO Specify | | | | Whi | ty: |
| | 15. DECEDENT'S EDUCATIO | | 16a DEC | EDENT'S U | PILAL OC | CUBATIO | A1 | 1 401 | . KIND OF BUS | | | . Le |
| COMPLEIED | (Specify only highest grade comp | pleted) | (Give | kind of wo | rk done de | uring mos | t of working | 0.55 | | | | . C D1 |
| 7 | Elementary/Secondary (0-12) Co | ollege (1-4 or 5+) | | | | 1 | December - | | | | | & Docks |
| Ē | 17. FATHER'S NAME (First, Middle, Last) | | ASS | Str | ucti | ıraı | Enginee | | | | Navy | - |
| | and the second s | | | | | | 18. MOTHER'S NA | | DOUGH TO SERVE | Sumame) | | |
| N N | Frank Leeds Bennett | | | | | | Hattie | | | | | |
| 2 ∦ | 19a. INFORMANT'S NAME (Type/Print) | | | | | | nd Number or Rural I | | | | | |
| _ | Helen Deile (Daught | er) | | | | | , Port R | epub | | - | | |
| | 20a. METHOD OF DISPOSITION 1 ☐ Burlel 2 ☑ Cremation 3 ☐ Removal | from State | other place | θ) | | | etery, cremetory or | | | CATION — | | |
| 1 | 4 Donation 5 Other (Specify) | | Metrop |)Olit | | | | | Ale | exand | ria, | Virginia |
| 1 | 21. SIGNATURE OF PUNERAL SERVICE LICENS | I | | | Ra | IUSC | h Funera | 1 Ho | me. 44 | 105 B | room | es Isl. Rd; |
| | トントラックボ | | | | | | Republic | | | | | |
| | 23. PART I. Enter the diseases, Dr comp | pilcations that ca | used the deat | th. Do no | | | | | | | | Approximate |
| | shock, or heart failure. List | only one cause | on each iina. | | | | | | | 0 | | Interval Between Onset and Death |
| | iMMEDIATE CAUSE (Finsi disease or condition | DOL | mon | . /- | | | | | | | | Oliset and Death |
| | resulting in death) a | | AS A CONSEQU | | | | | | | | | |
| - 1 | | | | | | | | | | | | İ |
| HILCALION | Sequentially list conditions, If any, leading to immediate | DUE TO (OR | AS A CONSEQU | IENCE OF): | | | | | | | | |
| ₹ | cause. Enter UNDERLYING | | | | | | | | | | | |
| Ĭ | CAUSE (Disease or injury that initiated events | DUE TO (OR | AS A CONSEQU | ENCE OF): | | | | | | | | |
| = | resulting in death) LAST | | | | | | | | | | | |
| 3 | DARTE II ON A LOUIS AND A STATE OF THE STATE | | | | | | | | | | | |
| DICAL | PART II. Other significant conditions co | ontributing to dea | th but not re | uiting in | the unc | darlying | cause given in | Part i. | 24a. WAS AN PERFOR | | 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 5 | 0.744.C B. | 4F1 35 | JWE | 4 | | | | _ | 1 YES 2 | □ NO | | COMPLETION OF CAUSE OF DEATH? |
| Ĕ | | | <u> </u> | | | | | | | | | 1 YES 2 NO |
| ż | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | SPITAL: | | | | | ACE OF DEATH (Ch | eck only or | 10) | | | |
| HTSICIAN: M | 1 TYES 2 NO | Inpatient 2 - ER | /Outpatient 3 | | OTHER Nursi | | 5 🗆 Residence | 6 🗆 Othe | r (Specify) | | | |
| - | 27. MANNER OF DEATH | 28a. DATE OF INJI (Month, Day, Y | | 28b. TIME INJUI | OF RY | 28c. INJU | JRY AT RK? | 28d. DE | CRIBE NOW I | NJURY OC | CURED | |
| 2 | 1 Natural 5 Pending Investigation | | | | М | 1 🗆 Y | ES 2 NO | | | | | |
| | 2 Accident investigation | | 81 AFFROY | e. farm. str | reet, facto | ry, office | | 28f. LOC | ATION (Street | and Number | or Rural | Boute Number |
| וַ כֵּ | 3 Suicide 6 Could not be | 28e. PLACE OF IN- building, etc. | (Specify) | -, | | | | | or Town. State! | | | |
| : ED | 2 Outolds | 28e. PLACE OF IN. building, etc. | (Specify) | -, | | | | | or Town, State) | | | |
| PLEIED | 3 Suicide 6 Could not be determined | building, etc. | (Specify) | | | ne, data | | City | | | | |
| OMPLEIED | 3 Suicide 6 Could not be 4 Homicide determined | i: To the best of my | (Specify) knowledge, deat | h occurred | at the tir | | and place, and due | City to the car | use(a) and ma | nnar aa ste | ted. | |
| COMPLETED | 3 Suicide 6 Could not be determined 29a. CERTIFIER (Check only | i: To the best of my | (Specify) knowledge, deat | h occurred | at the tir | | and place, and due | to the car | use(a) and ma | nnar aa sta nd dua to ti | ted. he cause(| a) and manner as stated. |
| N N | 3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On | i: To the best of my | (Specify) knowledge, deat | h occurred | at the tir | | and place, and due | to the car | use(a) and ma | nner ee sta ed due to th 29d. DAT | ted. he cause(| a) and manner as stated. D (Month, Day, Year) |
| | 3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: Of CENTIFIER | i: To the best of my | (Specify) knowledge, deat nation and/or in | h occurred | at the tir | | and place, and due | to the car | use(a) and ma | nner ee sta ed due to th 29d. DAT | ted. he cause(| a) and manner as stated. |
| N N | 3 Suicide 4 Homicide 6 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On | i: To the best of my | (Specify) knowledge, deat nation and/or in | h occurred | in the tire, in my op | olnion, de | and place, and due seth occured at the | to the car | use(a) and man | nnar as stared due to the 29d. DAT | ted. he cause E SIGNEI | a) and manner as stated. D (Month, Day, Year) |

who Davidson-Randell

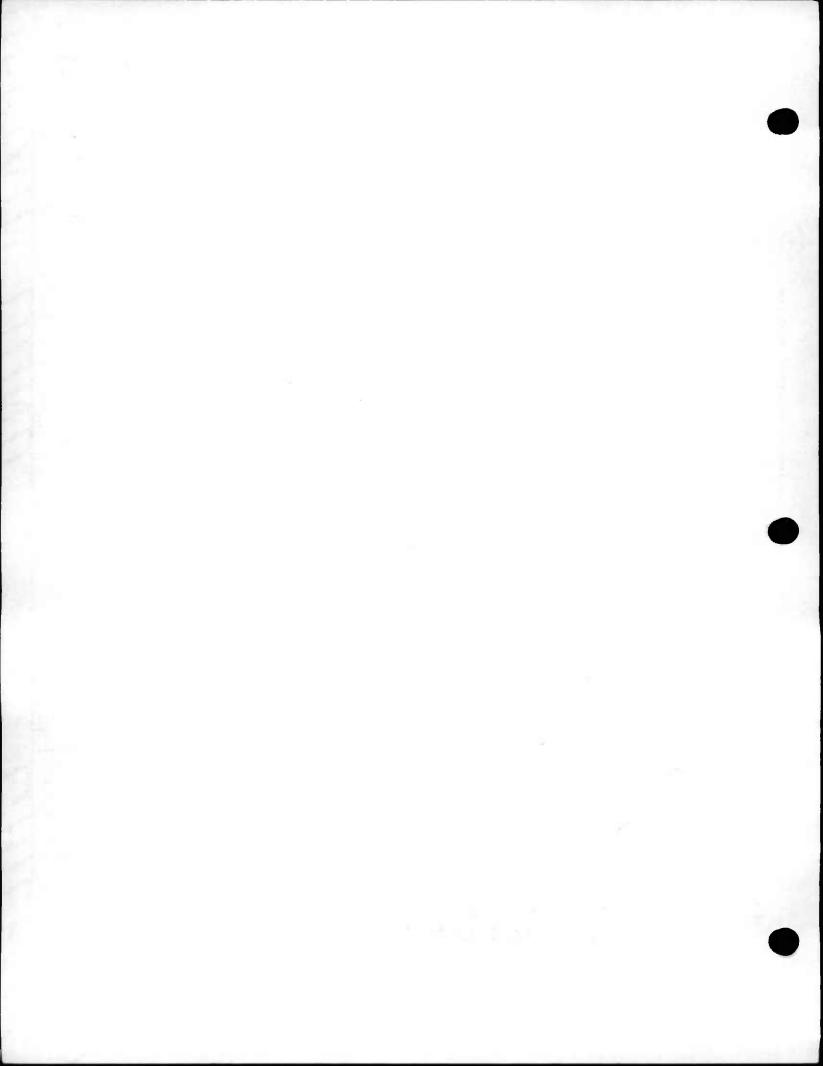
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Z-flours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

IMPORTANT: If Item 28 is marked, or item 23 shows ony injury, or other traumatic event, the medical examiner must be notified at once.

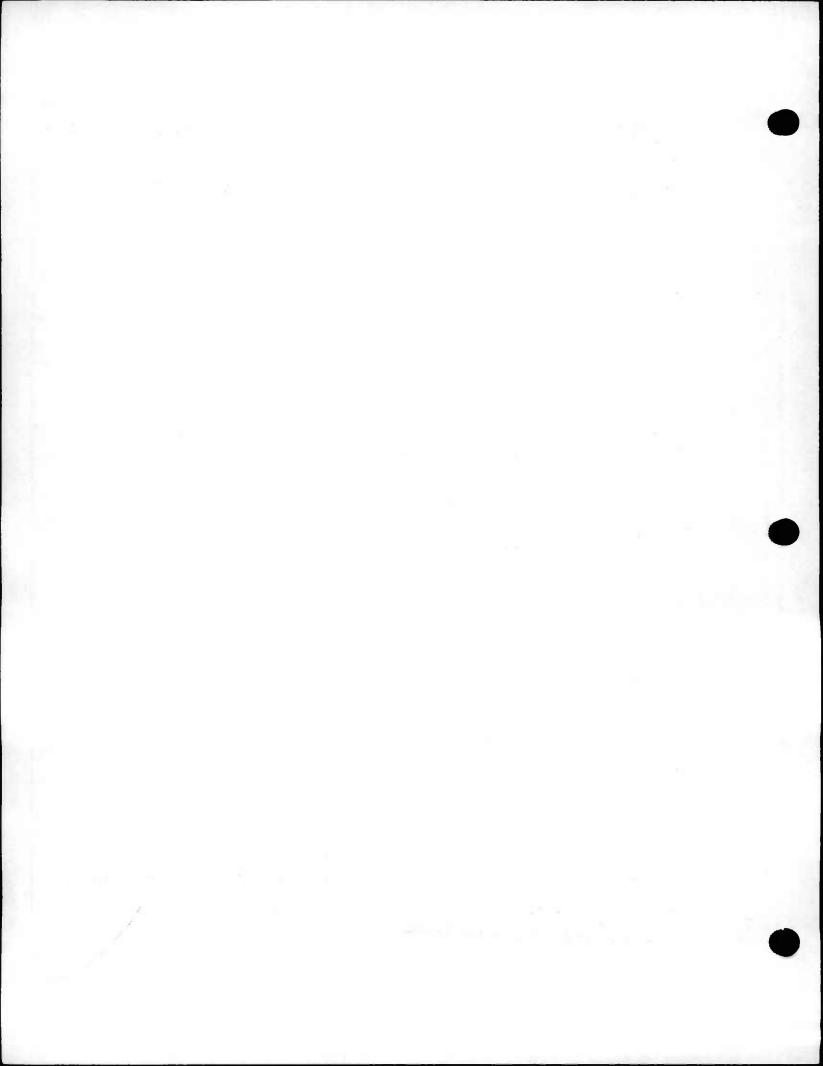
DEC

DHMH-16 Rev 1/89



FOR STATE REGISTRAR

| | 1 - STATE REGISTRAR | STATE OF M | ARYLAND / Ce | DEPAR | TMEN | T OF H | DEAT | AND I | MENTA | L HYGIEN | 7 | 0 | 34308 |
|------------------|--|---|-------------------------|------------------------|--------------------------------------|-------------|---------------------|-----------------|------------|------------------------------------|--------------|-------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) EMIL BAUMANN | | | | | | | | MONT | OF DEATH DA | 8, 19 | EAR 3. | 10345 a.m |
| œ | 4. SOCIAL SECURITY NUMBER 220 32 5307 98. FACILITY NAME (If not institution, give at CALVERT MEMORIAL | 1 M 2 F | 8. AGE (In yrs. less | YRS. | 9b. CITY | | HOURS FRED | MIN. | 9-3 ATH | OF BIRTH h, Day, Year) -07 | 9c, COUNT | BIRTHPLI Country) Hunga | |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | | Y, TOWN | OR LOCAT | | EKIC | K, F | ш о • | CAL | 10 | d. INSIDE CITY LIMITS? YES 2 7 NO |
| BY FUNERAL | 10e. STREET AND NUMBER 5783 Pindell Rd. 11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced | 12. WAS DECEDENT FORCES? 1 [IF YES, GIVE WA | YES 2 N | | | WAS DEC | ENDENT O | 711 F HISPAN | n, Puarto | N? (Specify Yea Rican, etc.) | USZ | A | American Indian, hite, etc. White |
| COMPLETED | 15. DECEDENT'S EDUI (Specify only highest grade Elementary/Secondary (0-12) 4 17. FATHER'S NAME (First, Middia, Last) | | (G/ | ve kind of Do NOT u | USUAL O work done se retired.) | during mo | et of workin | | | Mason | ry | TRY | *************************************** |
| BE | Jacob 19a. INFORMANT'S NAME (Type/Print) | | Treze | | | S (Street s | Ma | rie | | Middle, Malden | Bauma | | |
| 2 | Veronika Bauman: 20a. METHOD OF DISPOSITION 152 Burlel 2 Cremetion 3 Reme | | 20b. PLACE of other pla | ame of DISPO | as 1 | 0 ab | OVE | natory or | | 20c. LO | CATION — CIE | y or Town, | |
| | 21. SIGNATURE OF PUNERAL BERVICE LIC | io A | Sc | uthe | 22. | NAME AF | cial ADDRES Ch Fu | SS OF FA | CILITY | Dur ome, Ow | | | 20736 |
| | 23. PART I. Enter the diseases, or o shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | complications that List only one cause a. MUIF: | e on each line. | • | | | | ing, auci | n as car | diec or raapi | ratory arres | t, | Approximate interval Between Onset end Death |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | | OR AS A CONSEC | | | | | | | | | | |
| MEDICAL | PART II. Other algorificant condition | | lesth but not n | eculting | In the u | nderlyin | g cause (| given in | Part I. | 24s. WAS AN PERFOR 1 TYES 2 | MED? | AM CO | RE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | ER/Outpatient 3 | □ DOA | OTHE | R: | ACE OF D | | | | | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28a. DATE OF I | y, Ybar) | | M | 1 🗆 1 | PRK? YES 2 |] NO | 26d. DE | SCRIBE HOW II | NJURY OCCU | RED | |
| LETED | 3 Suicide 6 Could not be determined | building, e | INJURY — At hou | | | | | | City | ATION (Street a or Town, State) | | | e Number, |
| COMPLETED | (Check only 1 CERTIFYING PHYSI one) 2 MEDICAL EXAMINE | | | | | | | | | | | | d menner as stated. |
| TO BE | 296 SIGNATURE AND TITLE OF CERTIFIER 30 NAME AND ADDRESS OF PERSON WH | | E OF DEATH (ITEM | II 27) (Type | , Print) | | Dic | 22 | Q L | 2 | 29d. DATE S | | onth, Day, Year) |
| | Romile J Ro | CM W | PI | RINC | | EDER | ICK, | MD. | 206 | 78 | _ | | |
| | DEC 1 2 1990 | Jan Barr | dson-Hano | ماتلي | | | | | | | | | |



YEAR 90

3. TIME OF DEATH

4:24

PM

REG. NO.

28

2. DATE OF DEATH

MONTH

FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

Marie

5. SEX

Wendy

1 -

| e |
|-------------------|
| after |
| HOURS |
| uin |
| d with |
| e executed within |
| 2 |
| certificate |
| death |
| the |
| that |
| requires |
| A.P. |
| The |
| PHYSICIAN: |

4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS Pays HOURS None 1 M 2 1 F 11-05-90 Maryland Pages 1, 2, 3 should 9e. FACILITY NAME (If not institution, give street end number) 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF CEATH DIRECTOR UNIVERSITY HOSPITAL Baltimore Baltimore RESIDENCE OF DECEDENT 10b. COUNT 10c. CITY, TOWN OR LOCATION 10d, INSIDE CITY <u>Maryl</u>and Somerset Marion Station 1 YES 2 NO funeral director, page 5 should be detached for use as the burial-transit permit. FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? P.O. Box 339 21838 ath. Page 6 may be retained by the hospital or attending physician. 12. WAS DECEDENT EVER IN U.S. ARMÉD FORCES? 1 TYES 2 MO IF YES, GIVE WAR OR DATES 13. WAS DECEMDENT OF HISPANIC ORIGIN? (Specify Yee or No—
If yea, specify Cuban, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 11. MARYTAL STATUS 14. RACE — American Indian, Black, White, atc. 1 Never Merried 2 Merried BY Specify: White 3 Widowed 4 Olvorced 16e. OECEDENT'S USUAL OCCUPATION BE COMPLETED 15. OECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade compi Elementary/Secondery (0-12) College (1-4 or 5+) N/A N/A N/A notified at once. 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Bruce Edwin Brimer Amanda Mussolino 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 339. Marion Station. Mrs. Bruce Brimer 21838 Md must be 20e. METHOD OF DISPOSITION

1 © Burlel 2 □ Cremetion 3 □ Removal from State

4 □ Donation 5 □ Other (Specify)

21. SIGNATURE/OF FUNERAL SERVICE LICENSEE 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State Beechwood Cemetery Princess Anne. Md examiner 22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home M00295 n by the fi removal. Princess Anne. Md. 21838 the medical 23. PART / Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate signed by the attending physician and completely filled in by Health and Mental Hygiene prior to burial, cremation, or remo ahock, or heart fellure. List only one ceuse on each line. Interval Betwe Onset and Death IMMEDIATE CAUSE (Finel Kespintory disease or condition resulting in death) 30 min. 28 is marked, or item 23 shows any injury, or other traumatic event, DUE TO (OR AS A CONSEQUENCE OF): Encephalopathy 23 days HYPOXIC Ischemic PHYSICIAN: MEDICAL CERTIFICATION Sequentielly list conditions, OUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury Permata 23 days DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TES 2 NO 1 TES 2 NO has been a 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) this certificate ha HOSPITAL: SPITAL: OTHER: Inpatient 2 □ ER/Outpatient 3 □ DOA | 4 □ Nursing Home 5 □ Residence 8 □ Other (Specify) 1 TYES 2 NO 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural 5 Pending Investigation 1 YES 2 NO OR ATTENDING PI DIRECTOR: After the hours after death v BY 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Yown, State) 8 Could not be COMPLETED 4 Homicide TO THE HOSP: OR ATTO THE FUNERAL DIRECT
DE filed within 72 hours a
IMPORTANT: If Item 2 29e. CERTIFIER
(Check only one)

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(a) end manner ee stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated. THE FUNERA 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month Day, Year) BE 90 11/28 2 WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GoldiDo Melanic 22 South GRENE street, Baltimore A. 2/201 NOV 3 0

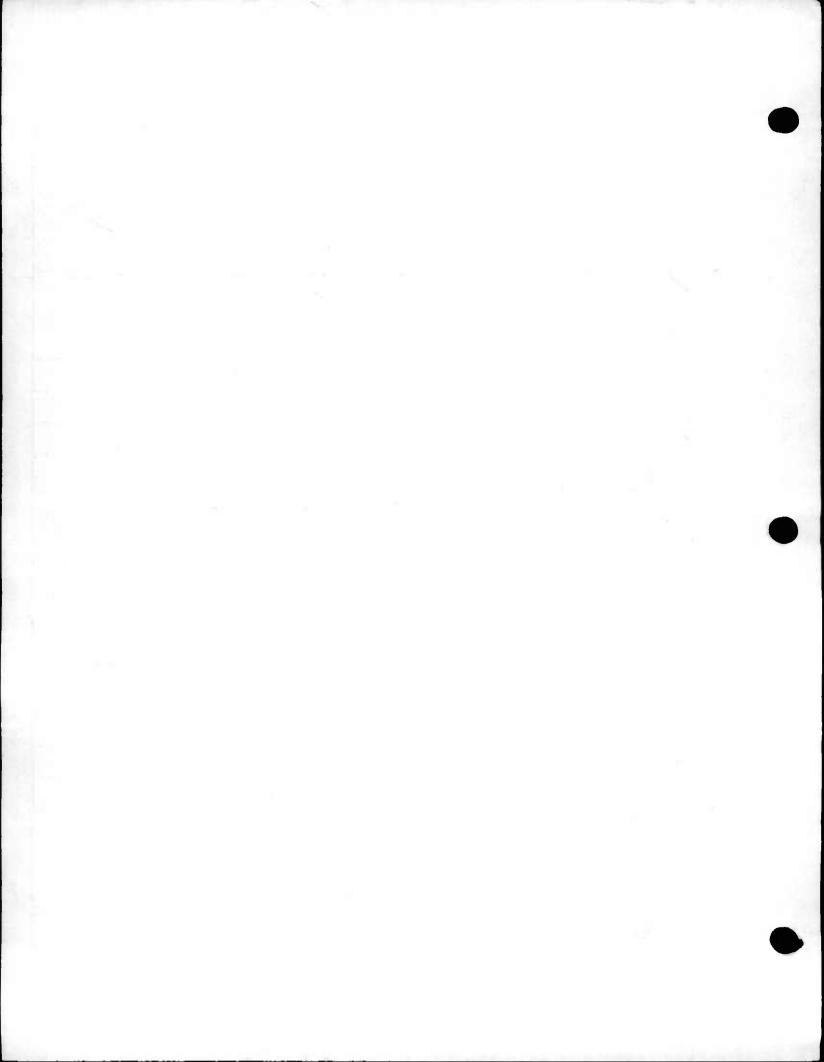
32. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

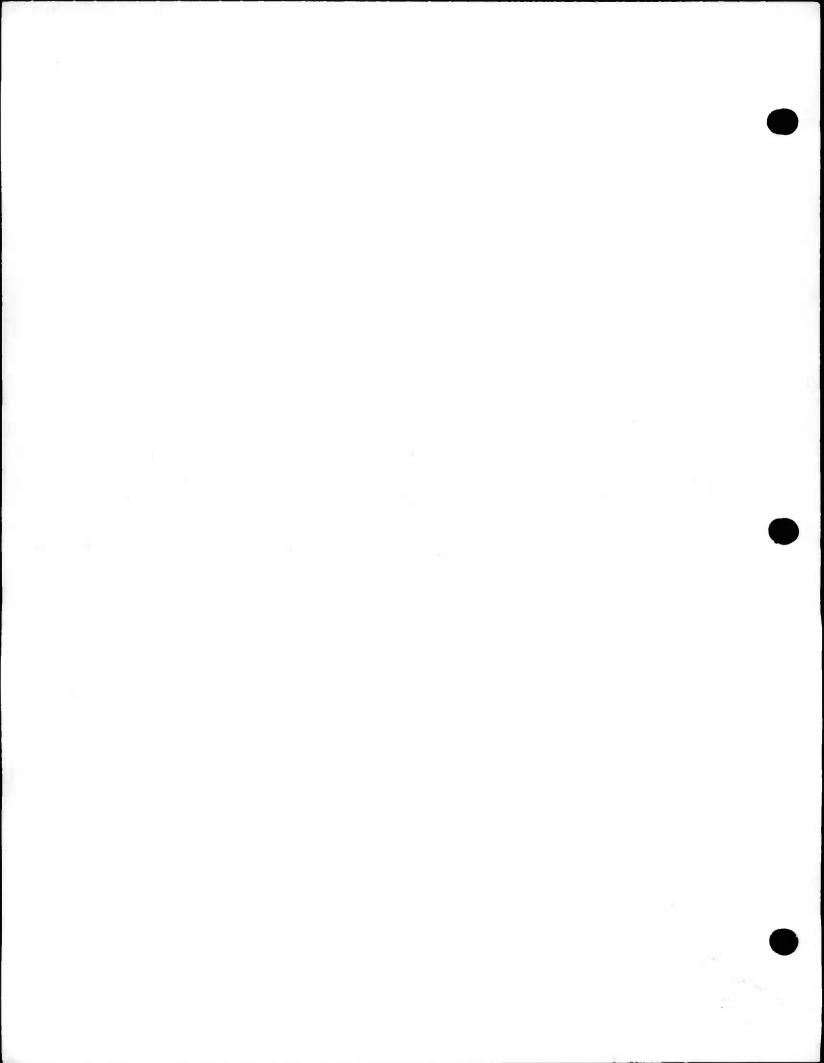
CERTIFICATE OF DEATH

Brimer



| K 13146, | e executed within 24-rours after death. Page 6 may be retained by the hospital or attent | an and completely filled in by the funeral director, page 5 should be detached for use as r to burial, cremation, or removal. | umatic event, the medical examiner must be notified at once. |
|--|---|---|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-rours after death. Page 6 may be retained by the hospital or attending physic | THE FUNERAL DIRECTOR: After this certificate has been signed by the amending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial be filed within 72 hours after death with the State Debt, of Health and Mental Hypiene prior to burial, cremation, or removal. | IMPORTANT: It fem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | MENT OF H | EALTH AND I | MENTA | L HYGIENI REG. NO. | | | |
|------------------|---|--|--|---------------------------------------|--|-------------------|-------------------------------------|-----------------------|--------------------------------|---|
| | 1. OECEOENT'S NAME (First, Middle, Last) John (nmn) | Bohonis | | | | MONT | OF OEATH | r vi | EAR | 6:30 A |
| | 4. SOCIAL SECURITY NUMBER 577-12-7240 90. FACILITY NAME (# not Institution, give s. | 5. SEX 6. AGE | 74 YRS. | UNDER 1 YEAR NITHS DAYS | F UNDER 24 HRS. HOURS MIN. R LOCATION OF DE | 7. DATE (Mont) | OF BIRTH h, Day, Year) | 8. | BIRTHPLA Country) | CE (State or Foreign |
| 5 | 5803 32ND Avenue | | | | sville | | | | | eorge |
| JIREC | 10e. STATE 10b. COUNTY | ice George | | ttsvill | | | | | | d. INSIDE CITY LIMITS? |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 5803 32ND Avenue | | 110 4 | 10f. | ZIP CODE | | | 109. CITIZEN | | T COUNTRY? |
| <u>a</u> | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT, SYER FORCES? 1 A YES | 2 NO | 13. WAS DEC | ENDENT OF HISPAN city Cuben, Mexice Z NO Specify | n, Puerlo | N? (Specify Yee Ricen, etc.) | | RACE — Bleck, W Specify: | American Indian, hite, etc. |
| COMPLEIED | 15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondery (0-12) | CATION completed) College (1-4 or 5+) | 16e. DECEDENT'S US (Give kind of work life. Do NOT use n | UAL OCCUPATION done during mostired.) | N It of working | 168 | . KINO OF BUS | INESS/INDUS | TRY | WII 00 |
| אלן | 12 17. FATHER'S NAME (First, Middle, Last) | 0 | Financin | g Offic | | | Bank | | | |
| 2 | Michael Bohonis | | | | Rosalie | | | | | |
| 2 | 190, INFORMANT'S NAME (Type/Print) Sonia B. Thompson | | | | nd Number or Rural I | Route Num | ber, City or Town | , State, Zip Co | de) | |
| | 2011 D. | | b. PLACE OF DISPOSITI | | eet Lau | irei, | | U/U/ CATION — City | or Town. | State |
| | 4 Donetion 5 Other (Specify) | oval from State | lary land No | ational | Memoria | 1 Pa | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE 1 IC | ENSEE) | ad L. | | Funeral | | ne. Inc | | | |
| 4 | 23. PART I. Enter the diseases, or o | xonxue | yey | 7601 | Sandy Sp | rinc | Road | Laure | | D 20707 Approximete |
| CENTIFICATION | iMMEDIATE CAUSE (Final dieeeee or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING | bDUE TO (OR AS | A | itota (| CANCER | | | | | Interval Between |
| | PART II. Other significant condition | | | tha underlying | j ceuse given in | Part i. | 24e. WAS AN PERFOR 1 TYES 2 | MED? | AM CO OF | FRE AUTOPSY FINDINGS AILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 110001711 | | | ACE OF OEATH (Ch | eck only o | ne) | | L | |
| THE STORE WELL | 1 YES 2 NO | HOSPITAL: 1 inpatient 2 ER/Out | patient 3 DOA 4 | | 5 A Residence | _ | | | | |
| | Natural 5 Pending | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WO | RK? | 28d. OE | SCRIBE HOW II | NJURY OCCUP | ŧΕΟ | |
| בס סבו | 2 Accident Investigation 3 Suicide 6 Could not be determined | 26e. PLACE OF INJUR building, etc. (Spe | Y — At home, term, atre | et, factory, offic | | | CATION (Street a or Town, State) | nd Number or | Rural Rout | e Number, |
| COMPLEIED | 000) | ICIAN: To the beat of my know | | | | | | | | nd manner ee stated |
| IO BE CO | 296. SIGNATURE AND TITLE OF CERTIFIE | Mary M | 10 | | 29c. LICENSE NUI | MBER | | | IGNEO (Me | onth, Day, Year) |
| | 36. NAME AND ADDRÉSS OF PERSON WHAT A CONTROL | KATZO | in My | P. | | | _ | | | |
| | MOV 0.5 '90 | Julia Davidoon | andell | | | | | | | |



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| | | physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, | |
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| 9 | heate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. | inal-tr | |
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| BALTIMORE, MARYLAND 21203-3146 | age | direc | |
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| BOX 13146, | a | physician and completely filled in by the | |
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| 10 THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. Pages 1, | be filed within 72 hours after death with the State Dept. of Heatth and Mental Hyglene prior to burial, cremation, or removal. | MPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

DIVISION OF VITAL RECORDS, P.O.

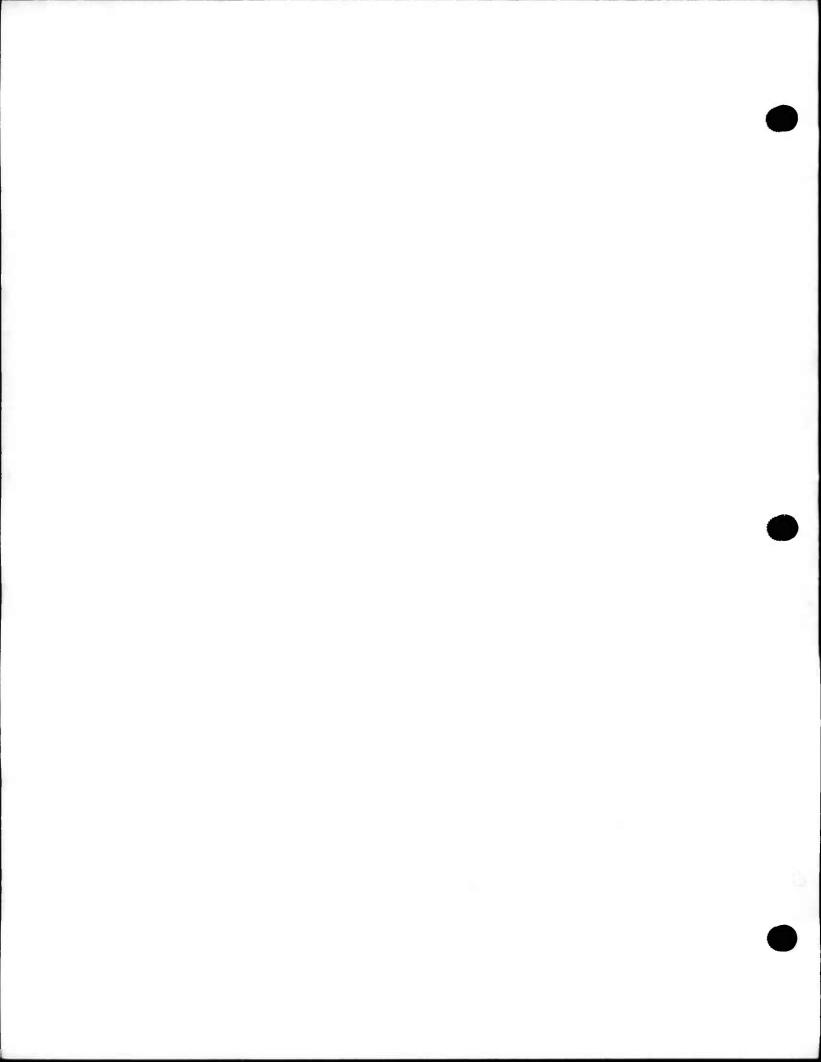
31. DATE FILED (Month, Day, Year)

100 3 0 190

32. REGISTRAR'S SIGNATURE

Davidson Randall

CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 11722/90 VIOLA BRIGHAM 11.30PM 4. SOCIAL SECURITY NUMBER 579-44-5080-A 5. SEX 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 10-21-1901 MARYLAND DAYS HOURS 1 - M 2 X F YRS. 9s. FACILITY NAME (if not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR PRINCE GEORGES HOSPITAL CENTER **CHEVERLY** PRINCE GEORGE RESIDENCE OF DECEDENT 10d. INSIDE CITY
LIMITS?
1 YES 2 NO 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION WASHINGTON, D.C. FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 312 44th STREET, N.E. 20019 U.S.A. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or Noif vea. specify Cuban, Mexicen, Puerto Rican, atc.) 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO IF YES, GIVE WAR OR DATES 14. RACE — American Indian, Black, While, etc. 1 Never Merried 2 Merried 3 Wildowed 4 Divorced If yes, specify Cuban, Mexicen, Puerlo Ri 1 YES 2 NO Specify: Specify: BLACK BY COMPLETED 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working
life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 18b. KIND OF BUSINESS/INDUSTRY (Specify only high /Elementery/Secondary (0-12) College (1-4 or 5+) HOUSEWIFE DOMESTIC 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) ROBERT PERRY FOREMAN MARTHA ELLEN BROWN BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 TRACEY L. CRADDOCK 5117 C STREET, S.E. #101 WASHINGTON, D.C. 20019 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20e. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 1 X Muriel 2 Cremellon 3 Ren 4 Donation 5 Other (Specify) MARYLAND NATIONAL PARK LAUREL, MARYLAND 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22 ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, N.E. WASH. D.C. 20019 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, Approximate Interval Between shock, or heert fellure. List only one cause on asch line. Onset and Death IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) andus DUE TO (OR AS A CONSEQUE DUE TO (OR AS A CONSEQUENCE OF) CERTIFICATION Sequentielly list conditions, If any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24e. WAS AN AUTOPSY MEDICAL 1 TES 2 NO 1 TYES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 TYES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. MANNER OF DEATH 260. DATE OF INJURY 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED Natural M 1 YES 2 NO BY 2 Accident 26a. PLACE OF INJURY — At home, farm, streel, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined COMPLETED 4 Homicide 1) SERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the lime, date end piece, end due to the cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(e) and menner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE anda 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chandar 60011 20 , trem and



| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | | |
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| 4 OF VITAL RECORDS, P.O. BOX | 13146, | |
| I OF VITAL RECORDS, | BOX | |
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| | VITAL | |
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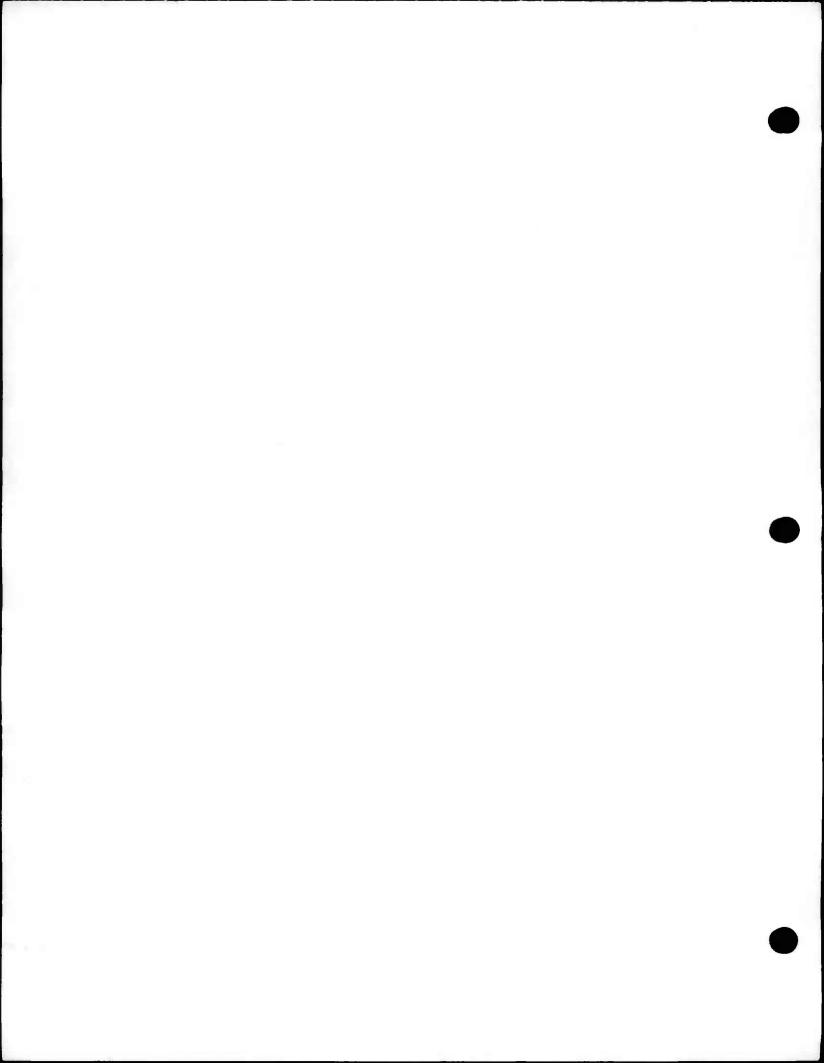
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 mours after death. Page 6 may be retained by the hospital or attending phys | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burity of filed within 72 hours after death with the State Dent of Health and Mental Horiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the fleed within 72 hours after death with the State Dept. of Health and | IMPORTANT: If item 28 is marked, or item 23 shows any |

| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | 3431 |
|-----------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Joseph P. Bachman 2. DATE OF DEATN MONTH DAY YEAR 11 19 90 8: | e OF DEATN |
| | 4. SOCIAL SECURITY NUMBER 179 03 9991 S. SEX 1 KKM 2 - F 8. AGE (In yrs. last birthday) 1 KKM 2 - F 8. AGE (In yrs. last birthday) 1 KKM 2 - F 8. AGE (In yrs. last birthday) 1 KKM 2 - F 8. AGE (In yrs. last birthday) 1 F under 1 Year F under 1 Year F under 1 Year F under 24 Hrs. 7. DATE OF BIRTH (Manth, Day 1961) 1 U.L. Y 14, 1905 PA | (State or Foreign |
| DIRECTOR | 96. FACILITY NAME (if not institution, give street and number) 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH 96. COUNTY OF DEATH MONTGOMET MONTGOMET | |
| L DIRE | 106. STATE 106. COUNTY 106. CITY, TOWN OR LOCATION 106. IN SILVER Spring 106. CITZEN OF WHAT CO | ISIDE CITY IMITS? YES 2 1 NO |
| FUNERAL | 3209 South Leisure World 20910 USA | |
| BY | 11. MARITAL STATUS 1 | rican Indian, , atc. te |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 18b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknwon Unknwon | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) Joseph P. Bachman 18. MOTHER'S NAME (First, Middle, Maiden Surname) Geoirianne Tribble | |
| TO B | 19a. INFORMANT'S NAME (Type/Print) Cathy Irwin 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12216 Malin Lane, Bowie, MD 20715 | |
| | 20e. METNOD OF DISPOSITION 1 Burlel 2 Cremetton 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cometer), crematory or George Washington University 20c. LOCATION — City or Town, State Washington, | |
| | 21. SIGNATURE OF FUNERAL SERVICE UCHNSEE 22. Mean appress of FACHTY transfer . 22. Mean appress of FACHTY transfer. NW Wash | 20 |
| | shock, or heart feliure. List only one cause on each line. | Approximste intervsl Between Onset end Death |
| CERTIFICATION | Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | |
| PHYSICIAN: MEDICAL CI | PERFORMED? 1 VES 2 NO OF DE. | AUTOPSY FINDINGS IBLE PRIOR TO LETION OF CAUSE ATH? (ES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO NO SPITAL: 1 inpetient 2 ER/Outpetient 3 DDA A Thursing Home 5 Residence 8 Other (Specify) | |
| ву РНУ | 27. MANNER OF DEATN XXX Natural 5 Pending 2 Accident Investigation 288. DATE OF INJURY (Month. Day, Year) 289. TIME OF INJURY AT WORK? 1 YES 2 NO 280. INJURY AT WORK? 1 YES 2 NO | |
| ETED. | 3 Suicide 8 Could not be determined 28s. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28s. CERTIFIER AND DESCRIPTION DEVELOPMENT TOWN, State) 28s. LOCATION (Street and Number or Rural Route No. City or Town, State) | umber, |
| COMPLETED | 29s. CERTIFIER (Check only One) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. (Check only One) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | nanner as stated. |
| TO BE (| 29b. SIGNATURE AND TITLE OF CERTIFIER Robert P. Fields, M.D. | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF OEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE
Julia Davidson Anna Davidson

31. DATE FILED (Month, Day, Year)
NOV 2 9 *90



TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYCICAL

| 1 - STATE REGISTRAR | | | | CERTIF | ICATE | OF DI | EAIH | | REG. NO. | | | |
|--|--|--|---|--|--|--|---|--|---|---|--------------|---|
| 1. DECEDENT'S NAME (First, | Middle, Le | si) | | | | | | | E OF DEATH | | | 3. TIME OF DEATH |
| Kenneth | Α. | Beard, Ji | | | | | | No | | w 1990 | YEAR | 9:35AM M |
| 4. SOCIAL SECURITY NUME | | 5. SEX | | In yrs. last birthday) | IF UNDER 1 | YEAR IF | UNDER 24 HRS. | 7. DAT | E OF BIRTH | 1990 | | IPLACE (State or Foreign |
| 216-40-6338 | | ₩XM 2 □ F | 47 | YRS. | MONTHS 5 | DAYS HO | OURS MIN. | _ | nth, Day, Year) | 1047 | Countr | (y) |
| 9a. FACILITY NAME (If not in | stitution, giv | ve street and number) | | | 9b, CITY, T | OWN OR LO | OCATION OF DI | LJa | n. 20, | 1943 | Wa. | shington, DO |
| 1249 Sho | | | | | | dgewa | | | | | | Arundel |
| RESIDENCE OF DEC | | | | | | | | | | | | |
| 10e. STATE | 10b. COU | | | | TY, TOWN OR | | | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | Anne | e Arundel | | | Edgewa | ter | | | | | | 1 TES 2 TO NO |
| 100. STREET AND NUMBER | | ive | | | | 101. ZIP | 21037 | | | - | U.S. | WHAT COUNTRY? |
| 11. MARITAL STATUS | | 12. WAS DECEDE | Ų,ĘYER II | Y U.S. ARMED | 13. WA | S DECEND | DENT OF HISPAI | NIC ORIG | GIN? (Specify Yes | or No— | 14. RACE | E — American Indian. |
| 1 Never Married 2 🔀 | | FORCES? | | | If y | | Cuban, Mexica | n, Puart | | | | k, White, etc. |
| 3 Widowed 4 Divo | rced | 1960-19 | | | '' | | A TTO OPEN | ,. | | | | asian |
| 15, DEC | EDENT'S E | DUCATION ade completed) | | 16a. DECEDENT'S | S USUAL OCC | UPATION | f working | 1 | 8b. KIND OF BUS | | | |
| Elementary/Secondary (0 | | College (1-4 or 5 | +) | Iffe. Do NOT | use retired.) | my most or | Working | | | | | |
| 12th | | N/A | | Plumber | <u> </u> | | | | Plumb | oing | Cont | ractor |
| 17. FATHER'S NAME (First, M. | | | | | | 18, | . MOTHER'S NA | ME (First | , Middle, Maiden | Surname) | | |
| Kenneth 1 | Altor | Beard, S | r. | | | | Margar | ret- | Collins | | | |
| 19a. INFORMANT'S NAME (7 | ype/Print) | | | 19b, MAILIN | G ADDRESS (S | | | | mber, City or Town | | Code) | |
| Gloria I | . Ros | rd | | Q: | me ac | 10 7 | N_F | | | | | |
| 20a, METHOD OF DISPOSITI | ION | annual from Cont. | 20b | PLACE OF DISPO | SITION (Name | of cemeter | n, cramatory or | | 20c. LO | CATION - | City or To | own, Stata |
| 4 Donation 5 Other | | emover from State | _ Ma | ryland S | State ' | Veter | rans Ce | emet | ery Ch | elte | nham | , Maryland |
| 21. SIGNATURE OF FUNERA | Selyince | School / | | | | | | | | | | me, Inc. |
| 1/1/1 | TOM | Wah | | | | 6633 | Old Al | exa | nder Fe | erry | Rd C | linton, Md |
| | | Charles Street Land | | | | | | | | 20 | 735 | |
| 23. PART f. Enter the di | iseases, e | or complications the | nt caused | the death. Do | | | | | | 20 | 735 | Approximata |
| IMMEDIATE CAUSE (Fir | eart fallu | re. List only one ce | use on e | ach line. | not anter th | na mode o | of dying, suc | h as ca | | 20 | 735 | |
| IMMEDIATE CAUSE (Fir disease or condition | eart fallu | re. List only one ce | use on e | ach line. | not anter th | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| IMMEDIATE CAUSE (Fir | eart fallu | s. GLI | 073 L | ach line. | not anter th | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata interval Setween |
| IMMEDIATE CAUSE (Findisease or condition resulting in death) | eart failui | s. GLI | 073 L | -ASTOM | not anter th | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| IMMEDIATE CAUSE (Fir disease or condition | ions, | s. GLI | OTS L | -ASTOM | not anter the | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| snock, or nr IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentisity list conditi if eny, leading to imme- cause, Enter UNDERLY! | lons, diate | s. GLI | OTS L | -ASTOM | not anter the | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentisity list condition if eny, leading to immecause. Enter UNDERLY CAUSE (Disease or injuthat initiated events | lons, diate | s | OTS LOOR AS A | -ASTOM | not anter the | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| Sequentially list condition resulting in death) Sequentially list condition if eny, leading to immecause. Enter UNDERLY CAUSE (Disease or injury) | lons, diate | s | OTS LOOR AS A | -ASTOM CONSEQUENCE | not anter the | na mode o | of dying, suc | h as ca | | 20 | 735 | Approximata Interval Between Oneat and Death |
| IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentisity list condition from the cause. Enter UNDERLY! CAUSE (Disease or Injusted in Interesting in death) LAS | lons, diate NG iry | s. GL) DUE TO DUE TO d. | OTS LOOK AS A DOOR AS A DOOR AS A | CONSEQUENCE | not anter the | NUL | of dying, suc | H as cs | erdiac or respi | 20 ratory sri | 735_rest, | Approximata Interval Between Oneat and Daeth |
| IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentisity list condition if eny, leading to immecause. Enter UNDERLY CAUSE (Disease or injuthat initiated events | lons, diate NG iry | s. GL) DUE TO DUE TO d. | OTS LOOK AS A DOOR AS A DOOR AS A | CONSEQUENCE | not anter the | NUL | of dying, suc | H as cs | | 20 ratory sri | 735_rest, | Approximata Interval Between Oneat and Daath Z3 M D S |
| IMMEDIATE CAUSE (Fir disease or condition resulting in death) Sequentisity list condition from the cause. Enter UNDERLY! CAUSE (Disease or Injusted in Interesting in death) LAS | lons, diate NG iry | s. GL) DUE TO DUE TO d. | OTS LOOK AS A DOOR AS A DOOR AS A | CONSEQUENCE | not anter the | NUL | of dying, suc | H as cs | erdiac or respi | AUTOPSY MED? | 735_rest, | Approximata Interval Between Oneat and Death Z3 M D S WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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TO THE FLANEAR DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. urs after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146 TO THE HIGHER OR ATTENDIAL PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 13146,

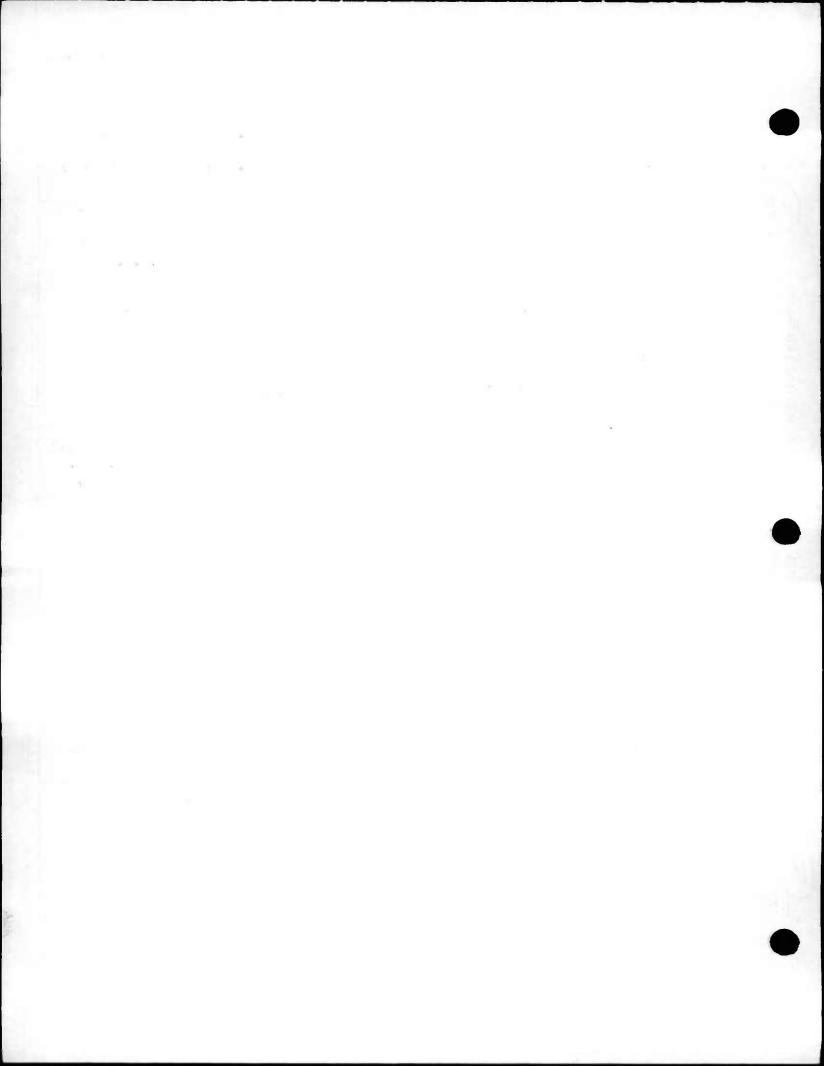
IMPORTANT: If them 25 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

> 31. DATE FILED (Month, Day, Year) '90

9 2

Savidson-Randall

DHMH-16 Flev 1/89



DIVISION OF VITAL RE

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

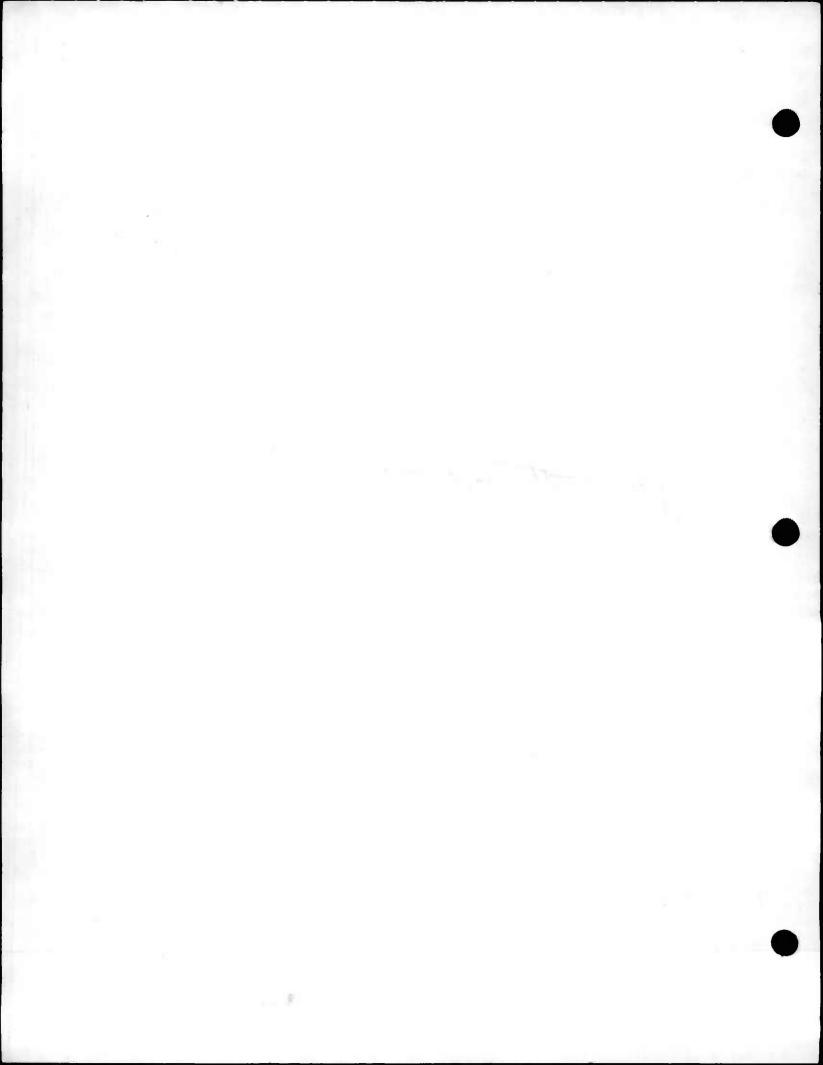
| 10 THE FUNCTIAL OF AN INCIDING PITALOGNAT. THE law requires that the does because within selection and program or assembly physician. TO THE FUNCTIAL DATA AN INCIDING A PRINCIPAL OF THE attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 money be fined within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
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| |

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | S | TATE OF MAR | | DEPARTI | | | | MEN | TAL HYGIENI REG. NO. | E | | |
|---|---|---|-----------------------------|--|-------------|---------------------|----------------------------|--------------|--|--------------------------|-------------|--|
| 1. DECEDENT'S NAME (First, M | AS G | omas Ge | | Biggs | | | ** | | ATE OF OEATH DA | | YEAR | 3. TIME OF DEATH 2:48 QM |
| 4. SOCIAL SECURITY NUMBER 578-44-0330 | 128 | M 2 □ F 8 | GE (In yrs. les | YRS. | | DAYS F | F UNDER 24 HRS. | 09 | ATE OF BIRTH Month, Day, Year) 0 06 06 | | Mary | land |
| SOUTHON RESIDENCE OF DECE | Marula | and He | opito | <u>u '</u> | b. CITY, TO | 14. | LOCATION OF D | EATH | | 9c. COU | P.6. | EATH |
| Maryland | Prince | e George | s | 10c. city, 1 | ildor | | N | | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 🏧 NO |
| 100. STREET AND NUMBER 16210 Bea | lle Hi | 11 Road | | | | 10f. Z | 1P CODE 2060 | 1 | | 10g. CIT | U.S. | VNAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 XM 3 Wildowed 4 Divorce | arried | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 13. WAS DECENOENT OF HISP If yes, specify Cuben, Max 1 ☐ YES 2 ☐ YNO Spe | | | | | fy Cuben, Maxic | an, Pu | | or No— | Speci | E — American Indian, k, Whita, etc. ity: Casian |
| (Specify only h Elementary/Secondary (0-1) | | lege (1-4 or 5+) | (Gi | CEDENT'S US ive kind of wor . Do NOT use i | k done dur | UPATION ing most | of working | | 18b. KIND OF BUS | | | |
| 7th 17. FATHER'S NAME (First, Midde Thomas Sim | | | l Fai | mer_ | | | и. мотнея s м Julia | | irst, Middle, Maiden | mino sumame) stead | | |
| 19a. INFORMANT'S NAME (Type Annabel Big | | | 191 | | as | | | Route | Number, City or Town | n, State, Ziji | o Code) | |
| 20e_METHOD OF DISPOSITION 1.A. Burlel 2 Cremation 4 Donetion 5 Other (S | | | other pla | ace) | | | ery, crematory or Cemet | ۵ ۲ ۲ | 100 | cation – | | wn, Stata aryland |
| 21. SIGNATURE OF FUNESAL | SERVICE LICENSE | | | 73 | 22. NA | ME AND | ADDRESS OF F | ACILIT | Lee Fu | mera | al Ho | ome, Inc. nton, Md 2078 |
| | irt fallura. List | olications that cau only one cause o | used tha da on aach lina | ath. Do not | t antar th | na mode | of dying, suc | ch aa | cardiac or respl | retory ar | rest, | Approximata Interval Batween Oneat and Death |
| iMMEDIATE CAUSE (Final disease or condition reaulting in death) | | nes DUE TO COR | S A CONSE | QUENCE OF): | evz | 7 | Fac | Į. | eve | 2 | | 16 mi |
| Sequentially list condition if any, isading to immedicause. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST | ata G | DUE TO (OR | AS A CONSECUTION | QUENCE OF | W es | The Dre | esper uslay | rof | alore | rel José | ref | 10+year |
| PART II. Other elgnificant | t conditions co | entributing to daa | th but not r | resulting in | the unde | arlying (| causa given in | Part | I. 24a. WAS AN PERFOR | MED? | 24t | AWAILABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? |
| 25. WAS CASE REFERRED TO | MEGICAL | | | | | | | | | | = | TES 2 NO |
| 25. WAS CASE REFERRED TO EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | нс | SPITAL: Inpatient 2 ER | IRY | DOA 4 | OF 2 | ig Home | | 6 🗆 | | NJURY OC | CURED | |
| 3 Suicide 6 C | ending veatigation ould not be starmined | 28s. PLACE OF IN. building, atc. | IURY — At ho | Pme, farm, str | M | | 5 2 [] MO | 281 | LOCATION (Street a | and Numbe | or or Rural | Route Number, |
| (order orny | | : To the best of my i | | | | | | | | | | s) and menner as stated, |
| 29b. SYGNANURE AND TITLE O | 280 | w | 25 | h-20 | 4 | | DIO | WBER O | 75 | 29d. DAT | TE SIGNED | S 90 |
| 30. NAME AND ADDRESS OF A TOTAL UTC. 31. DATE FILED (Month, Day, Ye | Soto | MPLETED CAUSE O A V E VZ 32. REGISTRAR'S | -AR | M 27) (Type, P | 91 | 3/ | Pisa | d | TAWA | yal | ÓC | WILLION |
| NOV 2 9 '90 | Ju | ia Davidson | | e | | | | | Y | | | 100, |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| REGISTRAR 1. DECEDENT'S NAME (First, Middle, Li | est) | | CERTIF | IOAIL | | | 2. DATE OF | REG. NO | | | A THE OF THE |
|--|--|--|--|--|--|--------------------------------|---|--|--|---|--|
| | alter | Brow | wn | | | | MONTH | DEATH D. | Y C | 90 | 3. TIME OF DEATH 1:20 A |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. i | | IF UNDER 1 YE | COMIT SE EMP | ER 24 HRS. | 7. DATE OF | | | | HPLACE (State or Foreign |
| 220 42 1042 | 1 📉 M 2 🗌 F | 43 | YRS. | | WS HOURS | | (Month, D | ay, Year) | 7.0 | Coun | try) |
| 9e. FACILITY NAME (If not institution, go | ive street and number) | 13 | | 9b. CITY. TO | WN OR LOCA | TION OF D | Jan. | 11 | _ | 47 | WashD.C |
| Malcolm Crow | Hospital | | | | | | | | | | George's |
| 10e. STATE 10b. COL | JNTY | | 10c. CIT | Y, TOWN OR L | OCATION | | | | | | 10d. INSIDE CITY |
| Maryland | PG | | Fo | restv | ille | | | | | | LIMITS? 112 XYES 2 NO |
| 10s. STREET AND NUMBER | | | | | 10f. ZtP CO | DE | | | 10g. Ct | TIZEN OF | WHAT COUNTRY? |
| 2111 Scott | Key Driv | е | | | 20 | 747 | | | IIr | i+0 | d States |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Divorced | 12. WAS DECEDED FORCES? IF YES, GIVE V | NT EVER IN U.S. / IV YES 2 DAIR OR DATES | ARMED NO | If ye | DECENDENT | OF HISPA | NIC ORIGIN? (S en, Puerto Rica y: | Specify Yearn, atc.) | or No- | 14. RAC Blac | E - American Indian, k, White, atc. |
| 15. DECEDENT'S a (Specify only highest gi | EDUCATION rade completed) | 18a. E | DECEDENT'S | USUAL OCCU | PATION | | 16b. KII | ND OF BUS | SINESS/IN | DUSTRY | |
| Etamentary/Secondary (0-12) | College (1-4 or 5 | +) " | me. Do NOT us | , | | | | | | | |
| 12th gráde | | U | J.S.P | ostal | Woke | er | | Got | 7. | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MO | THER'S NA | ME (First, Midd | lle, Maiden | Sumame) | | |
| George D. Br | own | | | | | E | stell | e Le | wis | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | ADDRESS (St | | er or Rural | Route Number, | City or Tow | n, State, Z | ip Code) | |
| Cynthia D. A | tkins Bro | | | Scot | | | ive | | | | |
| 20a. METHOD OF DISPOSITION 1 X Burlal 2 Crametton 3 R | lamovat from State | | | SITION (Name o | | | | 20c. LO | CATION - | City or To | own, Stata |
| 4 🗓 Donation 5 🗆 Other (Specify) _ | | Har | mony | Memo | | | | I | and | ove | r,Maryland |
| 21, SIGNATURE OF PUNERAL SERVICE | LICENS | . + | / | | E AND ADDR | | | | | | |
| | | TA | 7// | | ewart | | | | | | |
| 23. Part 1. Enter the diseases, ahock, or heart failu | or complications the | it caused that | death. Do n | 40 | 01 Bc | nni | na Do | 1 5c | 7 10 | reat, | Approximata |
| 23. PAPT 1. Enter the diseases, ahock, or heart fellu immediate CAUSE (Final disease or condition resulting in dasth) | NAROCI | it caused that cau | ALCOF | 40 antar tha | ∩1 Re moda of d | ying, suc | na Do | 1 5c | 7 10 | reat, | Approximata interval Between Onset and Death |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. NAROCI | FIC AND | ALCOH | HOL IN | ∩1 Re moda of d | ying, suc | na Do | 1 5c | 7 10 | reat, | intarvai Batwean |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate | a. NAROCT DUE TO DUE TO . | FIC AND | ALCOPSEQUENCE OF | 40 not antar that HOL INTERPRETED TO THE PROPERTY OF THE PROPE | ∩1 Re moda of d | ying, suc | na Do | 1 5c | 7 10 | Teat, | intarvai Batwean |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. NAROCT DUE TO b. DUE TO c. DUE TO | ISE ON AS A CONSI | ALCOF | HOL IN | Ol Remoda of d | TION | h aa cardiac | 1 5c | AUTOPSY MED? | | Interval Batwean Onaat and Death Onaat and Death were autopsy findings AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST | a. NAROCT DUE TO b. DUE TO c. DUE TO | ISE ON AS A CONSI | ALCOF | HOL IN | Ol Remoda of d | TION | h aa cardiac | or respi | AUTOPSY MED? | | Interval Batwean Onaet and Death Onaet and Death WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other aignificant condit | a. NAROCT DUE TO b. DUE TO c. DUE TO d | ISE ON AS A CONSI | ALCOF | Anot antar tha | O Remode of d | TION | Part I. 24 | or respi | AUTOPSY MED? | | Interval Batwean Onast and Death Onast and Death Were AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. NAROCT DUE TO b. DUE TO c. DUE TO d. HOSPITAL: | ISE ON AS A CONSI | ALCOH | Anot anter the HOL IN. F): F): OTHER: | MOT REMOVED TO TO TO TO TO TO TO TO TO TO TO TO TO | TION given in | Part I. 24 | or respi | AUTOPSY MED? | | Interval Batwean Onast and Death Onast and Death Were AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| INMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions of the conditions of th | B. NAROCT DUE TO b. DUE TO c. DUE TO d. HOSPITAL: 1 Inpatient 256 | COR AS A CONSI COR AS A COR AS A CONSI COR AS A COR AS A COR AS A COR AS A C | ALCOH- SEQUENCE OF SEQUENCE OF T resulting i | Anot antar tha | MOT REMOVED TO TO TO TO TO TO TO TO TO TO TO TO TO | TION given in | Part I. 24 | a. WAS AN PERFOR | AUTOPSY MED? | 24b | Interval Batwean Onast and Death Onast and Death Were AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of th | B. NAROCT DUE TO b. DUE TO c. DUE TO d. HOSPITAL: 1 Inpatient 256 (Month, D | ISE ON AS A CONSI (OR | ALCOH- SEQUENCE OF SEQUENCE OF Tesuiting is The sequence of th | Anot anter the | MODE OF Home 5 P | TION given in | Part I. 244 Part I. 244 Other (Sp. 28d. DESCRI | a. WAS AN PERFOR | AUTOPSY MED? | 24b | Interval Batwean Onaat and Death Onaat and Dea |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of th | B. NAROCT DUE TO b. DUE TO c. DUE TO d | COR AS A CONSI | ALCOHECUENCE OF EQUENCE OF tresulting is 28b. Time injuliately | Anot anter the | MODE OF THE PARK TO THE PARK T | TION given in | Part I. 244 Part I. 244 Other (Sp. 28d. DESCRII | a. WAS AN PERFORM YES 2 | AUTOPSY MED? NO NURY OC | 24b | Interval Batwean Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat Ona |
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| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other aignificant conditions of the condition of | B. NAROCT DUE TO b. DUE TO c. DUE TO d | COR AS A CONSI | ALCOH- SEQUENCE OF SEQUENCE OF The resulting is 3 DOA 28b. Time INJI 11:5 | Anot antar tha | MONTH OF THE PROPERTY OF THE P | given in | Part I. 24d Bock only one) B Other (Sp. 28d, Descriptor 76, 37. | a. WAS AN PERFOR VES 2 Decity) BE HOW the CT IN IN (Street a win, State) 39 Sil | AUTOPSY MED? NO SJURY OC JGEST nor as sta | 24b CCURED FED F or Or Burst II R PAF | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO DRUGS AND AI Route Number, 2K COURT |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other algnificant conditions and the conditions of t | B. NAROCT DUE TO b. DUE TO c. DUE TO d. DUE TO d. DUE TO d. DUE TO d. LIONAL STATE OF (Month, D. 1.1/21.26.) DUE TO DUE T | COR AS A CONSI | ALCOH- SEQUENCE OF SEQUENCE OF The resulting is 3 DOA 28b. Time INJI 11:5 | Anot antar tha | MONTH OF THE PROPERTY OF THE P | given in | Part I. 24d Bock only one) B Other (Sp. 28d, Descriptor 76, 37. | a. WAS AN PERFOR VES 2 Decity) BE HOW the CT IN IN (Street a win, State) 39 Sil | AUTOPSY MED? NO SJURY OC JGEST nor as sta | 24b CCURED FED F or Or Burst II R PAF | Interval Batwean Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat Ona |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other aignificant conditions of the condition of | B. NAROCT DUE TO b. DUE TO c. DUE TO d. DUE TO d. DUE TO d. DUE TO d. LIONAL STATE OF (Month, D. 1.1/21.26.) DUE TO DUE T | COR AS A CONSI | ALCOH- SEQUENCE OF SEQUENCE OF The resulting is 3 DOA 28b. Time INJI 11:5 | Anot antar tha | moda of d TOXICA Iying cause 8. PLACE OF Home 5 F NJURY AT WORK? YES 2 office data and place on, death occurrence, death occurrence, death | given in DEATH (Ch Residence | Part 1. 24 Part 1. 24 Other (Sp. 28d. DESCRII City or 76 37. to the cause(stime, date and teen | a. WAS AN PERFOR VES 2 Decity) BE HOW the CT IN IN (Street a win, State) 39 Sil | AUTOPSY MED? NO NUMBER NO NUMBER LVEF ner as stat d dua to t | CURED FOR PARTIES AND THE STONED | Interval Batwean Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat Ona |
| IMMEDIATE CAUSE (Final disease or condition resulting in dasth) Sequentially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in dasth) LAST PART II. Other algnificant conditions and the conditions of t | B. NAROCT DUE TO b. DUE TO c. DUE TO d. DUE TO d. LIONA CONTRIBUTING TO HOSPITAL: 1 Inpatient 256 28a. DATE OF (Month, D 11/21 28b. PLACE O building, HOUSE YSICIAN: To the best of sines: On the besis of ex- | COR AS A CONSI | ALCOH- SEQUENCE OF SEQUENCE OF REQUENCE OF | Anot antar that HOL IN. F): In the undaring the undarin | moda of d TOXICA Iying cause 8. PLACE OF Home 5 F NJURY AT WORK? YES 2 office data and place on, death occurrence, death occurrence, death | given in DEATH (Ch | Part 1. 24 Part 1. 24 Other (Sp. 28d. DESCRII City or 76 37. to the cause(stime, date and teen | a. WAS AN PERFOR VES 2 Decity) BE HOW the CT IN IN (Street a win, State) 39 Sil | AUTOPSY MED? NO NUMBER NO NUMBER LVEF ner as stat d dua to t | 24b CCURED FED F or Rural II R PAF Red. ha cause(ii | Interval Batwean Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat and Death Onaat Ona |



| BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mous after death. Page 6 may be retained by the hospital or attending physician, | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | tificate be executed | g physician and comi ene prior to burial, c | ther traumatic ev |
| ORDS, P.O. | that the death cer | ned by the attending th and Mental Hygi | any injury, or o |
| ITAL RECO | N: The law requires | cate has been sign State Dept. of Heal | item 23 shows |
| NON OF V | ENDING PHYSICIA! | OR: After this certified on the control of the cont | Is marked, or |
| DIVIS | HOSPITAL DR ATT | FUNERAL DIRECTO within 72 hours aft | TANT: If Item 28 |
| | THE | TO THE | IMPOF |

| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIENE REG. NO. | | | | |
|----------------------|--|--|--|----------------------------|---|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) OBLY 4. SOCIAL SECURITY NUMBER | DEAN | Beno | der | | 2. DATE OF DEATH DAY | 8 90 | 3. TIME OF OEATH 2307 M | | |
| | | 1 M 2 □ F | 36 YRS. MC | UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month, Day, Year) | 55 Vi | rginia | | |
| TOR | 9e. FACILITY NAME (If not institution, give since the second seco | reet and number) | 11/3 | b. CITY, TOWN C | PR LOCATION OF DE | ATH / | 9c. COUNTY OF GEATH | | | |
| DIREC | 10e. STATE 10b. COUNTY | e Arundel | 10c. CITY, T | OWN OR LOCAT | | | 10d. INSIDE CITY LIMITS? 1 □ YES 2*** NO | | | |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 796 Southern H: | ills Drive | | 101 | ZIP CODE 2101 | 2 | 10g. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Wildowed 4 X Divorced | 12. WAS DECEDENT, EVER IN FORCES? 1/A YES IF YES, GIVE WAR OR DA | | If yes, sp | ENDENT OF HISPAN ecify Cuban, Mexica 2 NO Specifi | IIC ORIGIN? (Specify Yee n, Puerto Ricen, etc.) | te or No— 14. RACE — American Indian, Black, White, atc. CauCasian | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) 1 2 + | | 16e. DECEDENT'S US (Give kind of work life. Do NOT use of Manager | | Marietta | | | | | |
| SON | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maiden | , | | | |
| BE | Robert Roland | Bender | Name and Address of the Address of t | izabeth F | | | | | | |
| 2 | Pan. INFORMANT'S NAME (Type/Print) Robert Roland | Bender | 196. MAILING AD USE | addres | ond Number or Rural in SS list | Route Number, City or Town ed above | 10e) | | | |
| | 20e. METHOD QE DISPOSITION 1 | oval from State | other place) 1etro Cr | | | | cation — city or to | own,State e, Maryland | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENDEE SOLL | ano D | Barra Seven | anco & na Par | Sons Fune k, Maryla | ral Ho | | | |
| | 23. PART 1. Enter the diseases, or | complications that caused List only one cause on a | tha death. Do not | entar tha mo | da of dying, auc | h as cardiac or reapli | ratory arreat, | Approximata | | |
| | iMMEDIATE CAUSE (Final disease or condition reaulting in death) | GUNS | hot- | W | ound | 14 | ead | interval Batwaan Onsat and Death | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DE TO UR AS A | CONSEQUENCE OF): | od | 9 | | | | | |
| PHYSICIAN: MEDICAL (| PART ii. Other aignificant condition | a contributing to death b | ut not reaulting in | the undarlyin | g cause givan in | Part I. 24a. WAS AN PERFOR 1 TYES 2 | MED? | b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | 26. Pi | LACE OF DEATH (Ch | eck only one) | | | | |
| SIC | EXAMINER? 1 X YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Outs | | OTHER: | ne 5 Deeldence | 6 Other (Specify) | | | | |
| | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Applicant Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 26b. TIME (| OF 28c. INJ | DRK? | 28d. DESCRIBE HOW II | NJURY OCCURED | 014. | | |
| TED BY | 2 Accident 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, atre | et, factory, offic | • | 261. LOCATION (Street e City or Town, State) | and Number or Rural | Route Number, | | |
| COMPLETED | and and | ICIAN: To the best of my know | | | | | | (e) and menner as atated. | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | G. The | MDI | Route | 29c. LICENSE NU | 6054 | 29d. DATE SIGNE | 2 9 9 0 | | |
| _ | 30. NAME AND ADDRESS OF PERSON WE | P. JON | es, m | nint) (| 695 | Amer | ica . | Ct. 21035 | | |
| | 31. DATE FILED (MORRY, Doy, Year) DEC 0 4 1990 Ju | his Javidson-Kons | ATURE | | | | | | | |

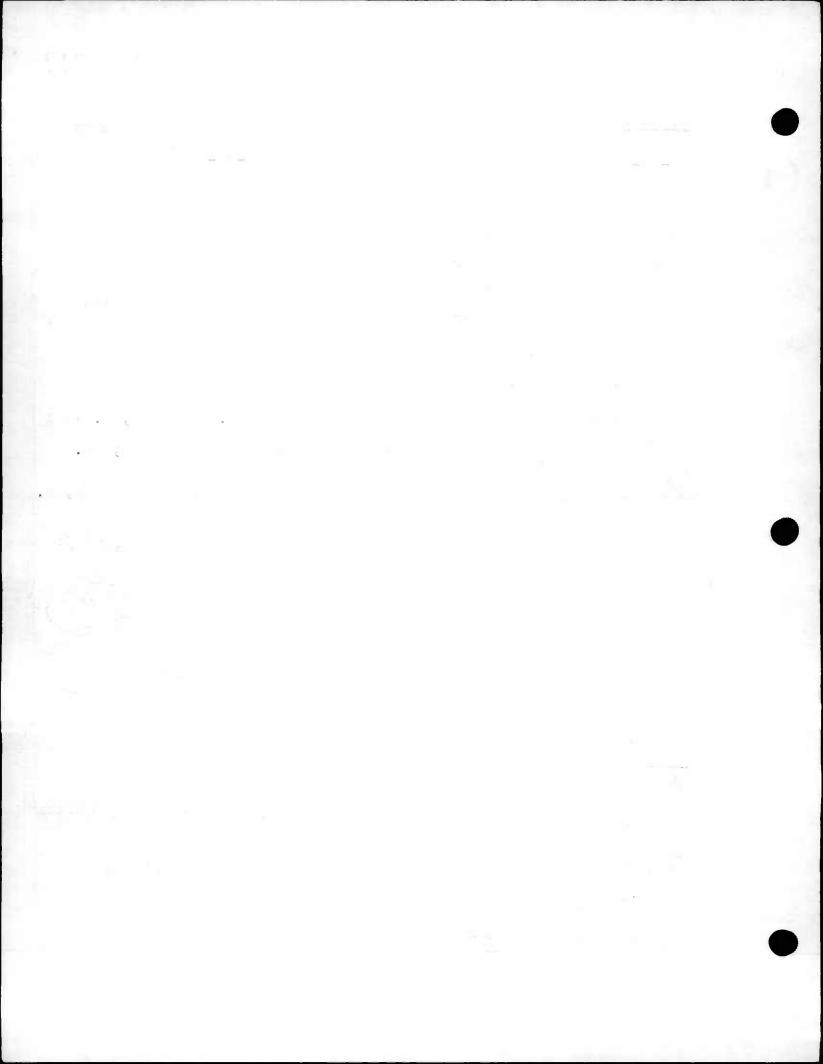
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| (6 | |
|--|---|
| BALTIMORE, MARYLAND 21203-3146 | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within sections after death. Page 6 may be retained by the hospital or attending physician. L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, a threet hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | L. OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a forward after death. Page 6 may be retained by the hospital or attending physician. L. DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transis hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY FUNERAL DIRECTOR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENT | AL HYGIENE |
|---|------------|
| CERTIFICATE OF DEATH | REG NO |

| 1. DECEDENT'S NAME (First, Middle, Last) | | | MENT OF HEAL CATE OF DE | | AL HYGIENE REG. NO. | | |
|--|--|--|--|---|--|--|---|
| | | OZITI II | JA 12 01 DE | | TE OF DEATH | | 3. TIME OF DEATH |
| DOCKEE EL | LIOTT B | OTESMO | KEE | | TH 12 DAY | 4 40 | 1845 M |
| | | 1100 | | NDER 24 HRS. 7. DAT | E OF BIRTN | A DUDTO | NPLACE (State or Foreign |
| 7 30-09-2497 9a. FACILITY NAME (If not institution, give stree | M 2 F | 86 YRS. | ONTHS DAYS HOU | | nth, Day, Year) -26-190 |)4 Nor | th Carolin |
| UNIVERSITY HOSPI | | 13 | b. CITY, TOWN OR LO | | | . COUNTY OF D | DEATN |
| RESIDENCE OF DECEDENT | IAL | | BALTI | MORE CITY | | | |
| 10s. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCATION | | | | 10d. INSIDE CITY |
| Maryland Anne | Arundel | | Annapa | olis | | | LIMITS? |
| 10e. STREET AND NUMBER | | 17 | 10f. ZIP (| | 10 | g. CITIZEN OF V | WHAT COUNTRY? |
| 6503 River C | rescent Dr | ive | | 21401 | | US | Α |
| 11. MARITAL STATUS V | 2. WAS DECEDENT EVER IN FORCES? 1 54 YES | J.S. ARMED | 13. WAS DECENDE | NT OF NISPANIC ORIG | GIN? (Specify Yea or N | No- 14 BAC | E - American Indian |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | | 1 YES 2 | uban, Mexican, Puart NO Specify: | o Rican, atc.) | Spec | k, White, atc. |
| | WWI | | | | | | White |
| 15. DECEDENT'S EDUCAT (Specify only highest grade co | | (Give kind of wor | BUAL OCCUPATION is done during most of w | orking | 86. KIND OF BUSINE | SS/INDUSTRY | |
| Elementary/Secondary (0-12) | Collega (1-4 or 5+) | | | | | | |
| | 5+ | Invest | ment Bar | | Securi | | |
| 17, FATHER'S NAME (First, Middle, Last) | | | 18. 1 | MOTNER'S NAME (First | | | |
| McKee Dui | nn McKee | | | Henriet | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | DDRESS (Street and Nu | | | | |
| Tanja McKee | | 6503 | River Cı | rescent | Dr.Anna | polis | Md.21401 |
| 20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Remove | at from State | omer piace) | ION (Name of cemetery, | | 20c. LOCATIO | ON — City or To | own, State |
| 4 Donation 5 Other (Specify) | | ethopol | itan Cre | M_ | Alex | andri | a, Va. |
| TURE OF FUNERAL SERVICE LICEN | | // | 22. NAME AND AD | DRESS OF FACILITY | | - | > |
| Thiolel X | . Ku to | _ | Mana T. | 13 | 3 (1) | 1800 | |
| 23. PART I. Enter the diseases, or con | nplications that caused t | the deeth. Do not | enter the mode of | dving such as co | T Unabe | L.W. m | Approximete |
| anock, or neart tellure. Lis | t only one cause on eac | h line. | | -yg, 520// 55 00 | and of respirato | The Contract of the Contract o | interval Between |
| IMMEDIATE CAUSE (Fine) | 1 6 | 10 00 | tongon A | | | 2 | Onset and Deeth |
| resulting in death) e | DUE TO (OR AS A | | down to DH IN | | | | II. a |
| | DOE TO (OR AS A C | | | | | - 1 | 12 Lays |
| | | ONSEGUENCE OF). | | | | - | Je Jans |
| Sequentielly list conditions, b | DUE TO (OR AS A C | | | | | - 1 | Suns |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A C | | | | | 124 124 | 2 Jays |
| if eny, leeding to immediata cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR AS A C | ONSEQUENCE OF): | | | | 12/2 | Le Jays |
| if eny, leeding to immediata cause. Enter UNDERLYING | | ONSEQUENCE OF): | | | | TA'S | 2 200 |
| if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | CONSEQUENCE OF): | | | | (M2) | \$ July 3 |
| if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | CONSEQUENCE OF): | the underlying cau | se given in Part i. | 24s. WAS AN AUTO | | WERE AUTOPSY FINDINGS |
| if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | CONSEQUENCE OF): | the underlying cau | se given in Part i. | PERFORMED | 7 | AMAILABLE PRIOR TO COMPLETION DF CAUSE |
| if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | ONSEQUENCE OF): | the underlying cau | se given in Part i. | | 7 | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | ONSEQUENCE OF): | the underlying cau | se given in Part i. | PERFORMED | 7 | AMAILABLE PRIOR TO COMPLETION DF CAUSE |
| If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A C | ONSEQUENCE OF): | | | PERFORMED 1 YES 2 4 | 7 | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| If emy, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A Contributing to death but | CONSEQUENCE OF): | 26. PLACE (| OF DEATH (Check only | PERFORMED 1 YES 2 U-4 | 7 | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| If emy, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A Contributing to death but | ONSEQUENCE OF): ONSEQUENCE OF): not resulting in | 26. PLACE C | OF DEATH (Check only | PERFORMED 1 YES 2 1 - 4 one) her (Specify) | NO | AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? |
| If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A Contributing to death but | CONSEQUENCE OF): | 26. PLACE CONTHER: Nursing Home 5 DF 28c. INJURY A WORK? | F DEATH (Check only Residence 6 Ot T 28d, D | PERFORMED 1 YES 2 A one) her (Specify) ESCRIBE NOW INJURE | RY OCCURED | AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 H-700 |
| If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A Contributing to death but CO CONTRIBUTION CONTRIBUTIO | ONSEQUENCE OF): ONSEQUENCE OF): not resulting in COC. | 26. PLACE CONTHER: Nursing Home 5 DF 28c. INJURY A WORK? M 1 YES | PEDEATH (Check only Residence 6 Only T 28d. D 22XNO SU | PERFORMED 1 YES 2 A one) ther (Specify) ESCRIBE NOW INJURED bject fe] | RY OCCURED | AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 VES 2 M-705 |
| If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of th | DUE TO (OR AS A Contributing to death but | ONSEQUENCE OF): ONSEQUENCE OF): not resulting in COSC. | 26. PLACE CONTHER: Nursing Home 5 DAY WORK? M 1 YES | PEDEATH (Check only Residence 6 Only T 28d. D 24XNO SU 261. LC | PERFORMED 1 YES 2 A one) her (Specify) ESCRIBE NOW INJUF DICATION (Street and N var Evan, Street and N | TY OCCURED Il on s Jumber or Rural F | AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 TO TO |
| If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other eignificent conditions of the conditions of the cause of the conditions of the cause | DUE TO (OR AS A Contributing to death but Local Characteristics and contributing to | consequence of): not resulting in cost lent 3 DOA 4 28b. TIME consulting in Al home, farm, stre | 26. PLACE CONTHER: Nursing Home 5 [Date Nursing Ho | PF DEATH (Check only Residence 6 ON 28d. D 29d. LC Ci An | PERFORMED 1 YES 2 4 one) her (Specify) ESCRIBE NOW INJUF DICATION (Street and N by or Rown, State) NAPOLLS Y | TY OCCURED 11 On S Jumber or Rural F | AMALABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 YES 2 TATO |
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| 1 - FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPARTA CERTIFIC | MENT OF HEA | ALTH AND M | ENTAL HYGIEN | | 00 04010 |
|--|---|--|---|--|--|---------------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. OATE OF DEATH | | 3. TIME OF DEATH |
| DOROTHEA | М. | В | URTIS | | | - | EAR |
| 4. SOCIAL SECURITY NUMBER | | | | IF UNDER 24 HRS. | 7. OATE OF BIRTH | 199 | BIRTHPLACE (State or Foreign |
| 213 48 5799 | 1 - M 2 - XF 94 | YRS. | HITHS DAYS H | OURS MIN. | (Month, Day, Year) uly 5,1 | | Country) Maryland |
| 9a. FACILITY NAME (If not institution, give st | , | | b. CITY, TOWN OR I | LOCATION OF DEAT | гн | 9c. COUNTY | OF DEATH |
| Anne Arundel M | edical Cen | iter | Annapo | olis | | Anne | Arundel |
| 10a. STATE 10b. COUNTY | , | 10c, CITY, T | OWN OR LOCATION | N | | | 10d. INSIDE CITY |
| Maryland An | ne Arundel | A | nnapol | is | | | LIMITS? |
| 10e. STREET AND NUMBER | | - | | IP COOE | | 10a. CITIZEN | OF WHAT COUNTRY? |
| 13 Locust A v | enue | | | 21401 | | | S.A. |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMED | 13. WAS DECENI | DENT OF HISPANIC | ORIGIN? (Specify Ye | | RACE - American Indian |
| 1 Never Married 2 Married | FORCES? 1 YES | DATES | If yes, specif | fy Cuban, Mexican, NO Specify: | Puerto Rican, etc.) | | Black, White, etc. Specify: |
| 3 🔀 Widowed 4 🗌 Divorced | | | | | | | White |
| 15. DECEDENT'S EDUC (Specify only highest grade | ATION completed) | 18e. DECEDENT'S USI (Give kind of work | done during most o | nt working | 16b. KIND OF BU | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | Ilfe. Do NOT use re | itired.) | a troining | | | |
| 1.2 | | Design | | | | rist | |
| Samuel F. Raw | 1 2 4 4 5 | | 1 | | (First, Middle, Maiden | -17.5 | |
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| Claire B. For | aler | | | | | | is.MD 21401 |
| 20g METHOD OF DISPOSITION 1 Burtel 2 Cremation 3 Remo | | Db. PLACE OF DISPOSITIO | ON (Name of cemete | ery, cremetory or | | | or Town, State |
| 4 Donation 5- Other (Specify) | oval from State | Cedar B | | | | | is, MD |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENBEE / | 1 / | 22 NAME AND | ADDRESS OF SACE | ITW | | |
| (Kash E | //we | / | Taylor | r Funer | al Chap er St., | | 21401 |
| | LICE DE LOVI | KA 06 | 1 44 7 3 7 4 | OHCEST | Ar ST | B MM B TIC | A T C MII |
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BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the Completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pabe filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

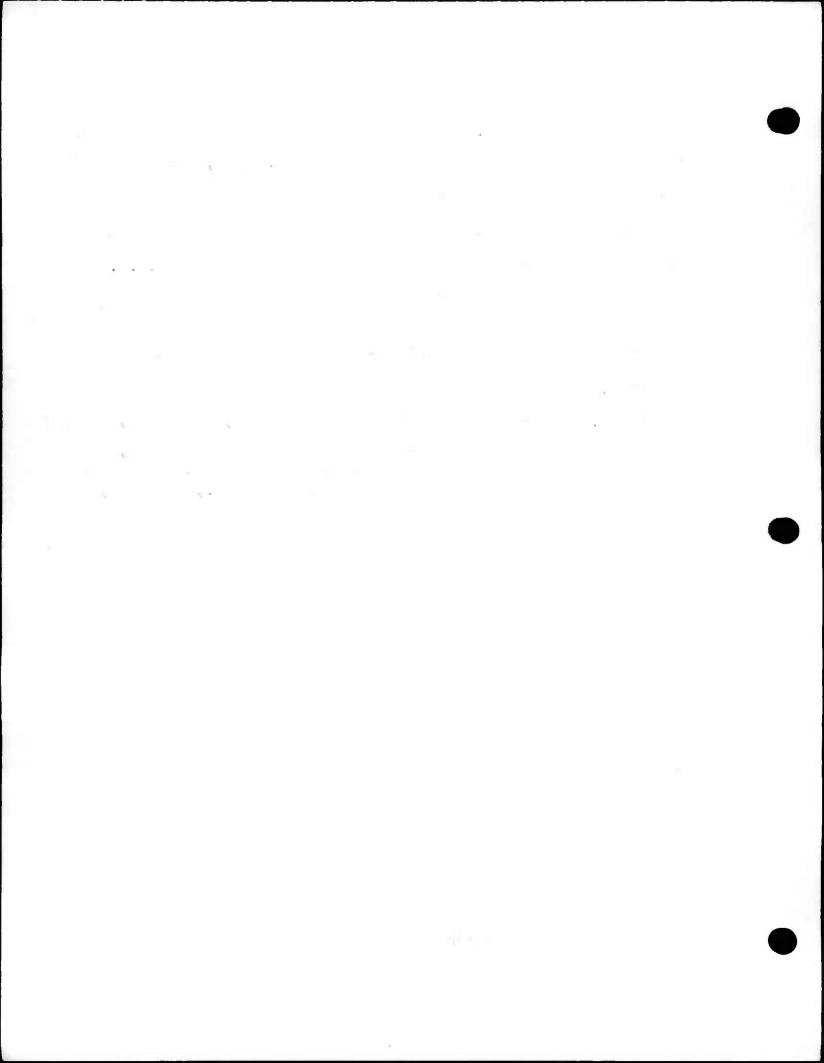
TO BE COMPLETED BY FUNERAL DIRECTOR

JERANKIN

32. REGISTRAR'S SIGNATURE

Lie Savidson-Rundare

Lie Savidson-Rundare



| | (| 3 50000 | | |
|--|--|--|--|---|
| BALIIMOHE, MAHYLAND 21203-3146 | ther death. Page 6 may be retained by the hospital or attending observed | certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-bansit permit. Pages 1, 2 3 stocks in the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal | al examiner must be notified at once. | |
| SINGLAND OF VITAL NECONDS, T.O. BOX 18146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the historical nor artending newspacetan | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furbe filed within 72 hours after death with the State Dept. of Health and Mertal Hyglene prior to burial, cremapion, or nemoval | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY BHYCICIAN: MEDICAL CERTIFICATION |

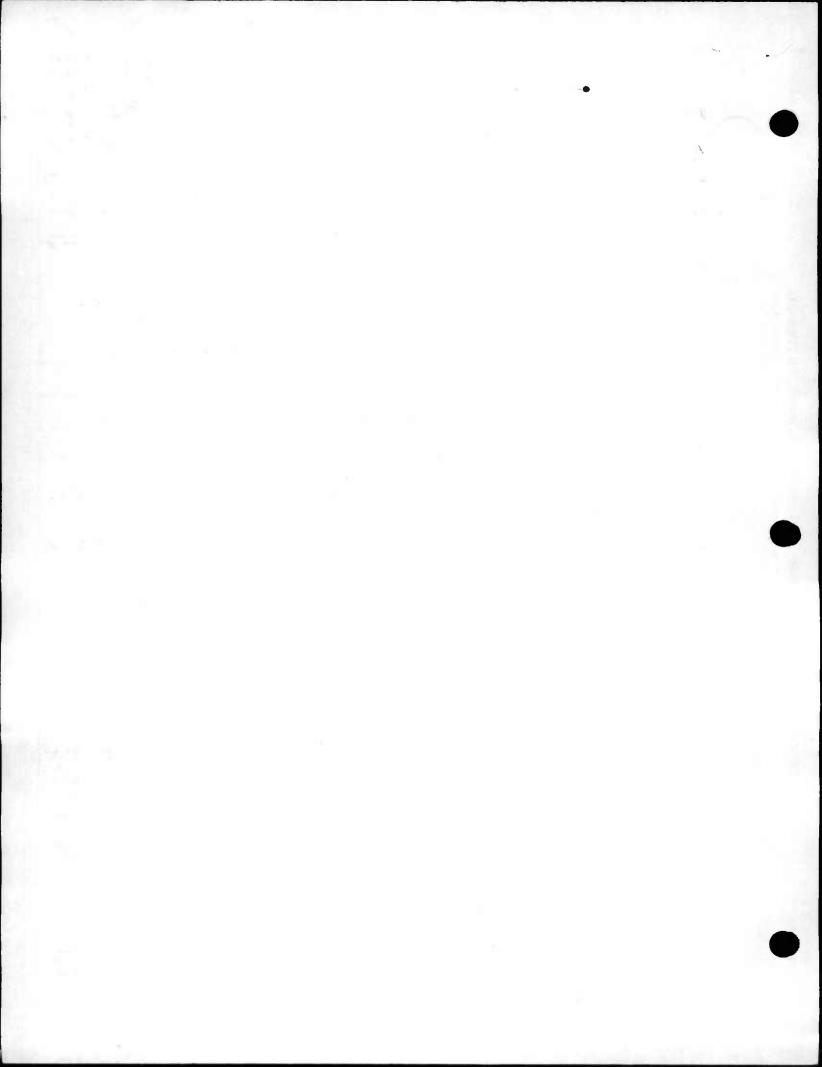
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | 1 - STATE REGISTRAR | STATE OF MARYLANI | D / DEPARTME | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN | _ | 0 34319 |
|----------------|--|--|-------------------------|---|---|-----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| | | HEODORE BOE | TTCHER, | JR. | Dec. 3, | 1990 | Р. м |
| | 4. SOCIAL SECURITY NUMBER | | i. last birthdey) IF UI | IDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRTH | IPLACE (State or Foreign |
| ١ | 216-22-3230 | 1 XM 2 □ F 62 | YRS. | HS DAYS HOURS MIN. | Mar. 25,1 | 928 Mar | vland |
| œ | 9e. FACILITY NAME (If not Institution, give s | | 9b. 0 | CITY, TOWN OR LOCATION OF | DEATH | 9c. COUNTY OF D | |
| DIRECTOR | 3284 Stepney | Street | | Edgewater | | Anne A | rundel |
| EC | 10e. STATE 10b. COUNT | | 10c. CITY, TOW | N OR LOCATION | | | |
| | Maryland Ann | e Arundel | | | | | 10d. INSIDE CITY LIMITS? |
| AL | 10e. STREET AND NUMBER | C I dild E.I | 1 11/12 | ewater 101, ZIP CODE | | 10g. CITIZEN OF V | 1 YES 2 NO |
| FUNERAL | 3284 Stepney | Street | | 2103 | 7 | U.S | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. | ARMED | 13. WAS DECENDENT OF HISP | ANIC ORIGIN? (Specify Yes | | - American Indian, |
| ВУ | 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES | □NO | If yes, specify Cuben, Mexi | cen, Puerto Ricen, etc.) | Bleci Speci | , white, etc. |
| | | W W II | | | | | ite |
| H | 15. DECEDENT'S EDU (Specify only highest grade | completed) | (Give kind of work do | ne during most of working | 16b. KIND OF BU | SINESS/INDUSTRY | |
| 7 | Elementary/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT use retire | Sales | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | 4 | Repres | entative | Pharm | aceutic | al Co. |
| Ö | | adama Pastas | h | | IAME (First, Middle, Maiden | | 1900 |
| BE | Frederick The 190. INFORMANT'S NAME (Type/Print) | ddore Boette | ner, Sr | ESS (Street and Number or Rura | ah Celest | yne Jon | es |
| 임 | Evelyn M. Boe | ttcher | | | | | |
| | 20a, METHOD OF DISPOSITION 1 Guriel 2 Cremetion 3 Remarks | 20b. PLA | CE OF DISPOSITION | tepney Str (Neme of cemetery, crematory or | eet, Edge | Water, I | MD 21037 |
| | 4 Donetion 5 Other (Specify) | oval from State other | piace) | Cemetery | | • | |
| | 21. SIGNATURE OR FUNERAL SERVICE LIC | Eysee () A | | 2. NAME AND ADDRESS OF F | ACILITY | napolis | , MD |
| | Maket J. | Jacola. | 1 | Taylor Fund | eral Chap | | 401 |
| \neg | 23. PART I. Enter the diseases or o | complications that save data | | 147 Glouces | ster St., | Annapol: | is,MD |
| | | List only one ceuse on sech i | lne. | er the mode of dying, su | ch es cerdiac or reepi | retory srreet, | Approximate interval Batween |
| İ | IMMEDIATE CAUSE (Final disease or condition | ν | | .LD | 1=1 | A F | Onest and Deeth |
| | resulting in deeth) | B. ULLULULULULULULULULULULULULULULULULUL | 1 Ver | stimber | Moderica | rolis. | |
| _ | _ | D1212 | imen | 1 00,10 | | | |
| CERTIFICATION | Sequentially list conditions, if sny, issding to immediate | DUE TO (OR AS A CONS | SEQUENCE OF): | | norien | | |
| S | ceuse. Enter UNDERLYING CAUSE (Disesse or Injury | 13chini | e Co | ndiomy | a am He | - | i |
| | thet initiated evants | DUE TO (OR AS A CONS | SEQUENCE OF): | | | - 1 | |
| Ä | resulting in deeth) LAST | . Cerenau | 7 Athe | 05dewo | c heart | disek | 50. |
| | PART II. Other significent conditions | s contributing to death but no | t resulting in the | | | | |
| SAL | Cumphon | | Trees and the | anderlying codes given in | Pert I. 24e. WAS AN. PERFOR | | WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO |
| PHYSICIAN: MED | It's M N | pucalem | 110. | | 1 🗆 YES 2 | → NO | OF DEATH? |
| 2 | - war a filter | Tancoura Contraction | ous. | | | | 1 TYES 2 TNO |
| ž I | 25. WAS CASE REFERRED TO MEDICAL | | | 28. PLACE OF DEATH (C | bot only only | | |
| Sic | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outpatient | 3 DOM OTH | ER: | | | |
| <u>₹</u> ∥ | 27. MANNER OF DEATH | 26s. DATE OF INJURY | 28b. TIME OF | ursing Home 5 Residence 28c. INJURY AT | 8 U Other (Specify) 28d. DESCRIBE HOW IN | HIDV OCCUPED | |
| ٨ | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | WORK? | Total BEGOINGE HOW IN | SONT OCCURED | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY — At building, etc. (Specify) | home, farm, atreet, fa | ictory, office | 28f. LOCATION (Street a | nd Number or Rural Br | uite Number |
| | 4 Homicide determined | Sulfaring, etc. (Specify) | | | City or Town, State) | | i variasi, |
| 7 | 29e. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of my knowledge, | death occurred at the | time, date and place, and due | to the councies and man | | |
| COMPLETED | one) 2 MEDICAL EXAMINER | t: On the beels of examination and/o | or investigation, in my | opinion, death occured at the | time, data and piece, and | dus to the cause(a) | and manner as stated |
| | 29L SIGNATURE AND TITLE OF CERTIFIER | | | 29c. LICENSE NU | | | |
| | The CXE | mon | 5 | N A | 0314 | 29d. DATE SIGNED (| Month, Day, Year) |
| 임 | 30 NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEATH (IT | TEM 27) (Type, Print) | 100 | 1 21 1 | - 00 | (10(7) |
| - | JEO PAI E () | angras i | | 205 Rid | gely B | ve Dr | NAPdome |
| | DEC 07 1990 | Acha Dairdson Hone | Lell | | | | 21401 |

F (N) - AC - 0

OHMH-16 Rev 1/89

| | _ | 1 - STATE REGISTRAR | STATE OF MAR | RYLAND / | DEPART | MENT | OF HEA | LTH AND | MENT | FAL HYGIE! | | | |
|---|---------------------|---|--|-------------------|-------------------------------|---------------------|------------------------------------|-----------------|-------------|--|----------------|-------------------------------|--|
| | $\uparrow \searrow$ | 1-DECEDENT'S NAME (First, Middle, Last) | | | | | | | | TE OF DEATH | | | 3. TIME OF DEATH |
| -(| D, | BRENDA K. | | | | | | | 2.0 | ov. 25 | , 100 | YEAR | 10:15A' |
| , | 1 | 4. SOCIAL SECURITY NUMBER 222-36-9695 | 1 M 2 X F 3 | NGE (In yrs. last | | F UNDER 1 | | UNDER 24 HRS. | 7. DA (M | TE OF BIRTH onth, Day, Year) 27/52 | - 1 | Country) | LACE (State or Foreign |
| prous | - | FACILITY NAME (If not institution, give | | | 9 | b. CITY, | TOWN OR L | OCATION OF I | | 21/02 | 9c. COUN | | |
| No. | ğ | 11 Alliance Dr | • | | | Che | sape | ake C | lity | 7 | Ceci | 1 | |
| Pages 1, 2,53 | DIRECTOR | 10e. STATE 10b. COUNT | TY | | 10c. CITY, | TOWN OR | LOCATION | | | | | | IOd. INSIDE CITY |
| 2 2 | 8 | Maryland Ceci | .1 | | Che | sap | eake | City | , | | | | LIMITS? |
| THE SECOND | ¥ | 10e. STREET AND NUMBER | | | | | | CODE | | | 10g. CITIZ | | AT COUNTRY? |
| an. | FUNERAL | 11 Alliance Dr | | | | | 21 | 915 | | | USA | | |
| 21203-3146 tal or attending physician. for use as the burlitami | BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR O | ES 2 NO | IED O | 11 | AS DECEND yes, specify YES 2 | Cuben, Mexic | an, Puer | GIN? (Specify Ye to Ricen, etc.) | a or No- | I4. RACE - Black, Specify: | - American Indian, White, atc. |
| attending se as the | ED | 15. DECEDENT'S EDU (Specify only highest grade | ICATION COMPRISED | 16e. DEC | EDENT'S US | UAL OCC | UPATION | | 1 | lab. KINO OF BU | SINESS/INDU | STRY | W112 0C |
| 212 Eal or Toru | LET | Elementary/Secondary (0-12) | College (1-4 or 5 +) | | e kind of won Do NOT use n | | ring most of | working | | | | | |
| AND 2 the hospital detached to once. | COMPL | 12 | | Hom | emak | er | | | | Homema | aker | | |
| LAP by the be dett | | 17. FATHER'S NAME (First, Middle, Last) Earl Lewis C | amaha 11 | | | | 18. | | | t, Middle, Maiden | | | |
| MARY retained to 5 should | 8 | 19a. INFORMANT'S NAME (Type/Print) | ambrett | 105 | MAN DIO AS | 22222 | | Li11 | ian | Jone | 25 | | |
| MARY e retained 5 Should notified | 5 | Charles E. Co | nover | | | | | | | imber, City or Tow | | | |
| BALTIMORE, MARYLAND or death. Page 6 may be retained by the hosp the funeral director, page 5 should be detached al. i examiner must be notified at once. | | 20e. METHOD OF DISPOSITION | | 20b. PLACE O | F DISPOSITI | ON (Name | of cometer | v. crematory or | nes | | Cation - c | | .21915 |
| DORE G may irector, p | | 1 Target 2 Cremetion 3 Rem 4 Donation 5 Other (Specify) | oval from State | FORE | | | | ,, | | | | | <u>Delaware</u> |
| ALTIM death. Pag tuneral di L. examiner | | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE | | | 22. N/ | ME AND A | DORESS OF F | ACILITY | | | | |
| SALT r death. re funera al. examil | | Koner C. A | Tutoliesor | N | | 21' | O M VTETU | Dwas | UTC. | HISON | FUNR: | L HO | MES |
| afte by the same | | 23. PART I. Enter the diseases, or a | complications that cau | sed the deat | th. Do not | enter th | ne mode d | of dying, su | ch ss ce | ordiac or resp | Inetory arres | own, | De.19709 |
| tely filled in mation, or t, the me | | shock, or heart failure. IMMEDIATE CAUSE (Finel disease or condition resulting in death) | e. Breas | n each line. | | | | | | | | , | Interval Between Onset and Death |
| 4 8 2 2 8 | | The color was a second | | S A CONSEQU | | | | | | | | | 1700 |
| and and matter | CERTIFICATION | Sequentially list conditions, if any, leading to immediate | b. DUE TO (OR A | IS A CONSEQU | ENCE OF): | | | | _ | | | | |
| icate be ohysician e prior le | 2 | CAUSE (Disease or Injury | c | | | | | | | | | | |
| th certificate ending phys Hygiene p or other | E I | that initiated events resulting in deeth) LAST | DUE TO (OR A | IS A CONSEQU | ENCE OF): | | | | | | | | |
| - E T E - | CEI | | d | | | | | | | | | | |
| that the ed by the th and M any Inje | MEDICAL | PART II. Other algolificant condition | s contributing to death | h but not res | sulting in t | he unde | orlying car | use given in | Part I. | 24s. WAS AN PERFOR | MED? | AV | ERE AUTOPSY FINDINGS MILABLE PRIOR TO OMPLETION OF CAUSE |
| requires een signe of Healtl | WE | | | | | | | | | 1 TYES 2 | NO | Of | F DEATH? |
| law re beept. c | | | | | | | | | | | | | _ 'rea r _ No |
| VIIAL IAN: The la tificate has e State De | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 100 | THER: | 26. PLACE | OF DEATH (Ch | eck only | one) | | | |
| Sertifican | 14S | 1 YES 2 NO | 1 Inpatient 2 ER/O | | DOA 4 | Nursing | - 0 | Residence | 6 🗆 Ott | ner (Specify) | | | |
| this of with with of | | Netural 5 Pending | 28e. DATE OF INJUR (Month, Day, Year | 7) | 28b. TIME OI INJURY | | WORK? | | 28d. OI | EŞCRIBE HOW II | NJURY OCCU | RED | |
| TENDING TOR: After after death | ВУ | 2 Accident Investigation 3 Suicide A Could set by | 28e. PLACE OF INJU | IRY — At home | form street | | 1 VES | 2 NO | 001.40 | | | | |
| R ATTEN RECTOR: urs after im 28 i | ETEO | 4 Homicide determined | building, etc. (S) | pecify) | , latin, stree | t, factory | , отнее | | 281. LO | CATION (Street a y or Town, State) | nd Number or | Rural Rout | Number, |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL DIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If Item 28 is marked, or Item 23 is | COMPLETED | 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINES | CIAN: To the best of my known or the basic of examinat | owledge, death | occurred at | the time my opin | , date end p | place, end due | lo the ci | ause(e) end men le end placa, and | ner as stated. | euse(a) an | nd manner as stated |
| HE HO HE FU Bd With | BE C | 296. SIGNATURE AND TITLE OF CERTIFIES | | | | _ | | LICENSE NUI | | | | | onth, Day, Yeer) |
| 5 5 3 W | 10 B | | 1, MD | | | | I | 153 | 14 | | > /// | 27/9 | 90 |
| | É | 30. NAME AND ADDRESS OF PERSON WHO Henry Farkas, N | O COMPLETED CAUSE OF I | DEATH (ITEM 2 | 7) (Type, Prin | #) ஓ 1 | 1ct on | Ma | ζ. | | | / | |
| | | JI. DATE FILED (MONIN, Day, Year) | 32. REGISTRAR'S SIG | GNATURE | | | N COL | , MC. | | | | | |
| | | NOV 28 '90 | Gulandi | 100 d/ser | Fandal | | | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial to filled within 72 hours after death with the State Debt. of Health and Mental Hyghene prior to burial, cereation, or removal. |
|--|
| IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Dey, Year)

Z - Z DEC 0 4

| FOR | | STATE OF I | /ARYLANI |) / DEPAR | RTMENT | NE H | FAITH | AND | MENTAL H | IVCIEN | ıc | 9 (|) ; | 34321 | |
|--|---|---------------------------|----------------|------------------------------------|---|---------------------------------|----------------------|------------|-------------------------|--|------------|----------------------------------|------------------------------|---|--|
| 1 - STATE REGISTRAR | | | | CERTIF | | | | | | EG. NO | | | | | |
| 1. DECEDENT'S NAME (First | DECEDENT'S NAME (First, Middle, Lest) Righard La Cla | | | | | air, Sr. | | | | 2. DATE OF DEATH DAY DAY DECEmber 2, | | | | E OF DEATH | |
| 4. SOCIAL SECURITY NUME | BER | 5. SEX | 8. AGE (In yrs | last birthday) | IF UNDER 1 | | | R 24 HRS. | 7. DATE OF E | HTRIE | 4, | 1990 8. BIRTH | HPLACE | (State or Foreign | |
| 209-12-9244 244 1 M 2 D F 64 YRS. | | | | | MONTHS DAYS HOURS MIN. | | | | (Month, Day, rear) Cour | | | | (Y) | lvania | |
| 9e. FACILITY NAME (If not institution, give street and number) Loch Raven Veterans | | | | | 9b. CITY, TOWN OR LOCATION OF DE | | | | | | | NTY OF DEATH | | | |
| Administration Hospital | | | | | Baltimore | | | | Balt | | | ltimo | timore City | | |
| 10s. STATE | IESIDENCE OF DECEDENT IB. STATE 10b. COUNTY 10c. CIT | | | | | | TY, TOWN OR LOCATION | | | | | | | | |
| | | | | | | lkton | | | | | LI | NSIDE CITY IMITS? YES 2 NO | | | |
| 10s. STREET AND NUMBER | | | | | | 101. ZIP CODE | | | | 10g. CITIZ | | | | | |
| 228 Locust | Lane | | | | 21921 | | | | | | | S.A. | | | |
| 11. MARITAL STATUS | | 12. WAS DECEDEN | | | 13. W | 13. WAS DECENDENT OF HISPANIC (| | | | IIC ORIGIN? (Specify Yee or No. 14, R/ | | | ACE — American Indian, | | |
| 1 Never Merried 2 3 Wildowed 4 Divo | | FORCES? 1 | AR OR DATES | | | | elly Cube 2 NO | | an, Puerto Ricer | n, etc.) | | Blac | Black, White, atc. Specify: | | |
| | | | | /8/52 | | | | | | | | | W | White | |
| (Specify only | EDENT'S EDU y highest grade | completed) | | (Give kind of life. Do NOT u | B USUAL OCCUPATION work done during most of working | | | | 16b. KIN | D OF BU | SINESS/IN | DUSTRY | | | |
| Elementary/Secondary (0 |)-12) | College (1-4 or 5 | -) | | Driver | | | | Stone Quarry | | | | | | |
| 17. FATHER'S NAME (First, M | liddle, Last) | | | - | | _ | 16. MOT | HED'S N | AME (First, Middle | | | -1 | | | |
| Len | us C | lair | | | | | iu. mor | rich 3 IV. | Larue | | olon | | | | |
| 190. INFORMANT'S NAME (7 | ype/Print) | | | 19b. MAILING | ADDRESS (| Street a | d Numbe | r or Rural | Route Number, C | City or Tow | n State 7i | n Codel | | | |
| Anna Hollen | baugh | | | | Locust | | | | Elkton | | | 1921 | | | |
| 20e. METHOD OF DISPOSITI | n 3 🗆 Rem | oval trom State | Othe | ce of dispos r place) ospect | | | | | | | CATION — | | | le | |
| 21. SIGNATURE OF FUNERA | L SERVICE LIC | CENSEE \ | | | | | | | for Fi | | | | | | |
| > \ . | . 0 | 7/.1 | 1 | | | Boy | and | d St | ockton | Str | eets | P.A. | • | | |
| 23. PART I. Entar tha di | lanacan Dr | nmplications the | Coursed the | death Dr. | | Elk | ton | . MD | 2192 | 2.1 | | | | | |
| ahock, pr hi iMMEDIATE CAUSE (Fin disease or condition reaulting in daath) | aart Tallura. | Liat pnly ona cau | se on each | ine. | C. | ے ب | e br dy | di | ch aa cardiac | or reapi | ratory ar | reat, | ir | Approximata ntarval Batwean Onsat and Death | |
| | _ | DUE TO | (OR AS A CON | SEQUENCE | F): | | Jor | | | | | | | | |
| Sequantially list conditi if any, landing to imma- | diata | DUE TO | OR AS A CON | SEQUENCE O | F): | · · · | | 1 (6 | | | | | - | | |
| cause. Entar UNDERLYi CAUSE (Diseasa Dr Inju | | с | | | | | | | | | | | _ | | |
| that initiated events resulting in death) LAS | | DUE TO | (OR AS A CON | SEQUENCE O | F): | | | | | | | | | | |
| Trouting in deadily 270 | | d | | | | | | | _ | | | | | | |
| PART II. Other significa | nt condition | contributing to | death but no | t resulting | in the unde | arlying | cause | given in | Part i. 24a | . WAS AN | AUTOPSY | 24b. | . WERE / | AUTOPSY FINDINGS | |
| PART II. Other significa | SOPL | rager | vice | | | | | | 1.5 | PERFOR | MED? | | AVAILAE | BLE PRIOR TO ETION OF CAUSE | |
| | 1 | J | | | | | | | '' | _ TES 2 | □ NO | | OF DEA | | |
| | | | | | | | | | | | | | 1 11 | ES 2 NO | |
| 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | | | | | 26. PL | CE OF D | EATH (C | heck only one) | | | | | | |
| 1 YES 2 | | HOSPITAL: | ER/Outpatient | 3 DOA | OTHER: | g Home | 5 🗆 Re | eldence | 8 Other (Spi | ecify) | | | | | |
| | Pending Investigation | 26a. DATE OF (Month, D | | 28b. TIM | URY | 8c. INJU WOF | |] NO | 26d. DESCRIE | BE HOW II | NJURY OC | CURED | | | |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. PLACE OF INJURY — At home, farm, street, f. | | | | | | | | | | | | | nber, | | |
| 29e. CERTIFIER | FYING PHYS | CIAN: To the beat of | my knowledge. | death occurre | ed at the time | e, dete | nd place | and des | to the councin | and mo- | Det en et- | lad | | | |
| one) 2 MEDI | CAL EXAMINE | R: On the basis of e | | | | | | | | | | |) end mı | inner as stated. | |
| 296. SIGNATURE AND TITLE | OF CERTIFIE | h / . | 2 | \sim | | | 29c. LICE | ENSE NU | MBER | 23 | 29d. DAT | E SIGNED | (Month. | Day Year) | |

21202

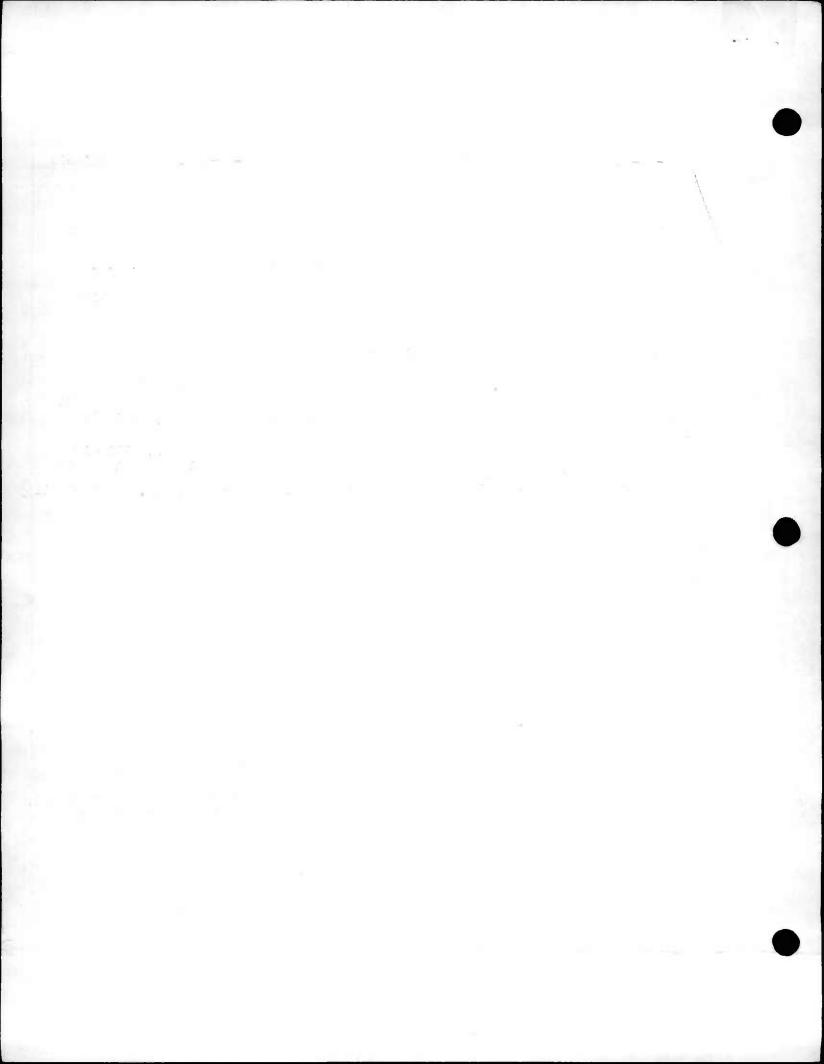
32. REGISTRAR'S SIGNATURE

Julia Davidson Randelle

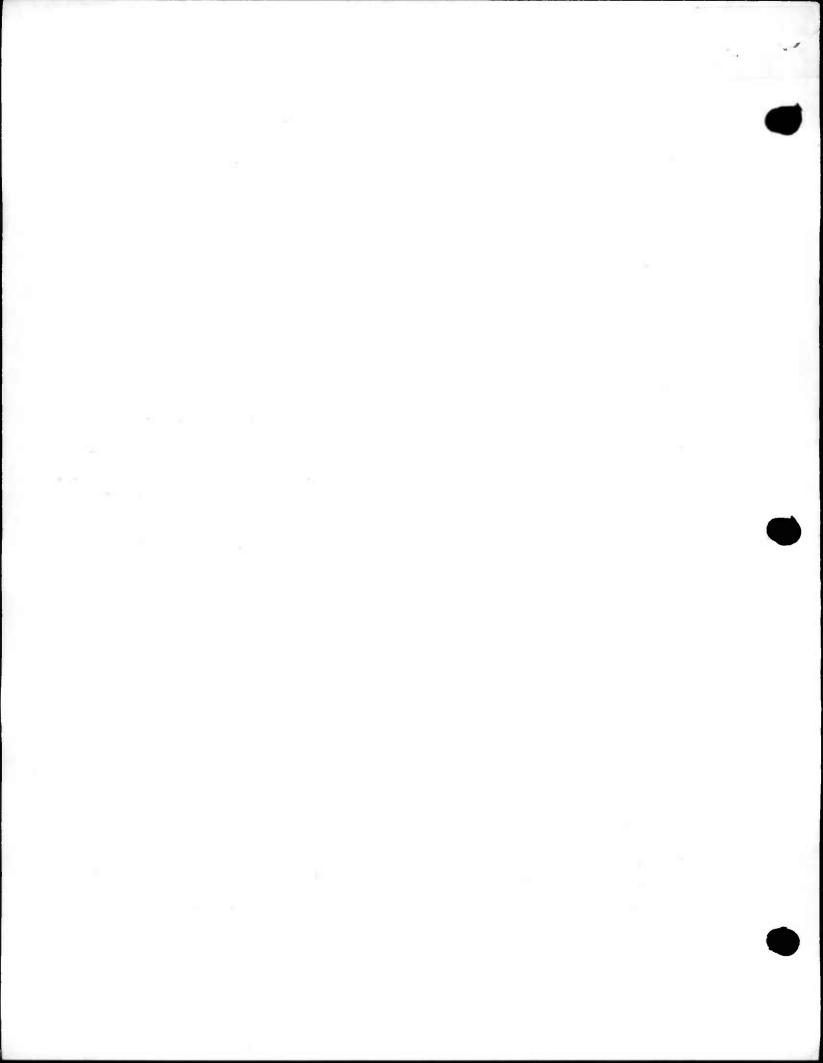
31. DATE FILED (Month, Day, Year) NOV 3 0 '90

| 100 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | DEATH | 2. DAT | TE OF DEATH | | | 3. TIME OF DEAT | |
|-----------------------------|--|--|--|--|--|--|---|--|---|--|--|--|
| 179 | Jan | mes · | Thoma | as | Crumb | Crumb | | MONTH DAY 11-20-90 | | year 1:15AM | | |
|) | 4. SOCIAL SECURITY NUMBER | 1 | 6. AGE (In yrs. | . last birthday) | IF UNDER 1 YEAR | # UNDER 24 HRS | 7. DAT | 7. DATE OF BIRTH | | 8. BIRT | HPLACE (State or Fo | |
| 1. | 340-44-7103 | 1 M 2 - F | 39 | YRS. | MONTHS DAYS | HOURS MIN | (Mo | nth, Day, Year) 5-30-19 | 51 | Coun | Illino | |
| 1 4 | 9e. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, TOWN | OR LOCATION OF | | | - | INTY OF I | | |
| CTOR | 4017 Cottage Te | errace | | | Brenty | | | Pri | nce | Georges | | |
| FUNERAL DIREC | 10e. STATE 10b. COUNT | | | 10c. CIT | Y, TOWN OR LOCA | TION | | | | | 10d. INSIDE CITY | |
| | Maryland | Prince Ge | eorges | | Brentwood | | | od | | | LIMITS? | |
| | 10e. STREET AND NUMBER | | | | 10 | 101. ZIP CODE | | | | IZEN OF | WHAT COUNTRY? | |
| RE | 4017 (| | 20722 | | | | U. S.A. | | | | | |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. | | | | | ANIC ORIGIN? (Specify Yee or No- | | | 14. RACE — American Indian Black, White, etc. | |
| ВҰ | 3 Widowed 4 X Divorced | IF YES, GIVE WA | R OR DATES | | 1 TYES | | | | | | White | |
| 60 | 15. DECEDENT'S EDU | CATION | 16a. | DECEDENT'S | USUAL OCCUPATION | ON | 10 | 6b. KIND OF BU | SINESS/INI | DIJETRY | | |
| COMPLET | (Specify only highest grade Elementary/Secondery (0-12) | College (1-4 or 5+) | | (Give kind of w life. Do NOT us | rock done during me | ost of working | " | | | - 40 i Ni | | |
| MP | 10 | | Printer | | | | | Prin | ting | | | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S | NAME (First | , Middle, Maiden | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | Donald A. | | | | | Mar | garet | McCor | rmiel | k | |
| 6 | The state of the s | | | | ADDRESS (Street a | | | | | | 6064 | |
| | Don Shatner 5000 West Lawrence Avenue Chicago Illinois | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 13.0 Burlel 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cametery, cremetory or other place) Graceland Cemetery Chicago, Illinois | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIE Prickad P 23. PART I. Enter the diseases, or about or heart failure. | marguelle complications that | caused tha | deeth Do n | 3981 | Carrol | FACILITY ton | Marzul: | lo Fu | inera | al Servi Maryland | |
| | 23. PART I. Enter the diseases, or abook, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Practical Contact | ct qun | deeth. Do n | 3981 ot enter the mo | Carrol | FACILITY ton | Marzul: | lo Fu | inera | al Servi | |
| ERTIFICATION | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition | Complications that clist only one cousts a. Contact Due To (c) Due To (c) | CT GUN: | deeth. Do n ina. Shot w | 3981 ot enter the mo | Carrol | FACILITY ton | Marzul: | lo Fu | inera | Maryland Approxime | |
| R | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | Contactor of the complications that contactor of the cont | CT GUN DR AS A CONS DR AS A CONS | deeth. Do nina. Shot we sequence of seque | 3981 ot enter the mo | Carrollda of dying, su | Lton ach ea ca | Marzul Road Ur rdiac or respi | lo Fu | inera | Al Servi Maryland Approxime interval Be Onset and | |
| MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Contactor of the complications that contactor of the cont | CT GUN DR AS A CONS DR AS A CONS | deeth. Do nina. Shot we sequence of seque | 3981 ot enter the mo | Carrollda of dying, su | Lton ach ea ca | Marzul Road Ur rdiec or respi | lo Fu | inera | Al Servi Maryland Approxime interval Be Onset and | |
| MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | Complications that can be considered by the control of the can be control of the can be control of the can be can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be control of the can be can be control of the can b | CT GUN DR AS A CONS DR AS A CONS | deeth. Do nina. Shot we sequence of the seque | 22. NAME AI 3981 of enter the mo ound of | Carrollda of dying, su | Lton ach ea ca | Marzul Road U rdiec or respi | lo Fu | inera | Approxime Interval Be Onset and Onse | |
| MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | Contactor of the complications that contactor of the cont | OR AS A CONS | deeth. Do n ina. Shot w sequence of sequence of it resulting is | 22. NAME AI 3981 ot enter the mo | Carrol da of dying, su head cause given i | Lton uch ea cal | Marzul Road Urdiac or respi | lo Fu | inera | Approxime Interval Be Onset and Onse | |
| 2 | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | DUE TO (O | CT GUN: OR AS A CONS OR AS A CONS OR AS A CONS eath but not | deeth. Do n ina. Shot w sequence of sequence of it resulting is | 22. NAME AI 3981 ot enter the mo ound of : : : : : : : : : : : : : : : : : : : | Carrol da of dying, su head cause given i | ton Ich ea cal In Part I. | Marzul Road Urdiac or respi | AUTOPSY MEO? | 24b | Approxime Interval Be Onset and Onse | |
| MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reauting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? XXMINER OF DEATH 1 Natural 5 Pending Investigation | DUE TO (O d | OR AS A CONS OR AS | deeth. Do n ina. Shot we sequence of sequence of the resulting in the sequence of the sequenc | 22. NAME AI 3981 of enter the mo ound of it the underlying 26. PL OTHER: 4 Nursing Homo of of of of of of of of of of of of of | Carrol da of dying, su head cause given i | ton ich ea cai in Part I. | Marzul Road Urdiac or respi | AUTOPSY MEO? NO SCE | 24b | Approxime interval Be Onset and Onset and Onset and Approxime interval Be Onset and On | |
| ED BY PHYSICIAN: MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? **XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | DUE TO (O | CT GUN: OR AS A CONS OR AS A CO | Shot We Sequence of the resulting in 1:00 home, farm, staree be | 22. NAME AI 3981 ot enter the mo ound of it the underlying the second of | Carrol Carrol da of dying, su head cause given i Ace of Death (Co 5 Residence JRY AT RKY KS XXX NO | n Part I. | Marzul Road U rdiac or respi 24a. WAS AN PERFOR YES 2 ATTO (Specify) SCRIBE HOW IN CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (Street a CATION (STREET a C | AUTOPSY MEO? SCE SUBJURY OCC. | 24b 24b 27ccccccccccccccccccccccccccccccccccc | Approxime Interval Be Onset and Onse | |
| BY PHYSICIAN: MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reauting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 20e. CERTIFIER (Check only one) | DUE TO (O | CT GUN: OR AS A CONS OR AS A CO | Shot We SEQUENCE OF SEQUENCE O | 22. NAME AI 3981 ot enter the mo ound of it the underlying the underlying 28c. INJ WO of PY Preet, factory, office chind ho | Carrol da of dying, su head cause given i ace of Death (Co 5 Residence JRY AT RRY RRY NO DUSE end place, end du | n Part I. Check only of eXXonh 28d. DE 281. Low 401 Printle to the ce | Marzul: Road U: rdiac or respi 24a. WAS AN PERFOR XX YES 2 ine) er (Specify) Escribe How in If infi Cation (Street a Cation (Street a Cation (Street a) C | AUTOPSY MEO? SCE SUBJURY OCC. ICTE OFF SE SEE | 24b 24b 24b 27c 24b 27c 27c 27c 27c 27c 27c 27c 27 | Approxime Interval Be Onset and Onse | |
| ED BY PHYSICIAN: MEDICAL CE | 23. PART I. Enter the diseases, or ahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | DUE TO (O | CT GUN: OR AS A CONS OR AS A CO | Shot We SEQUENCE OF SEQUENCE O | 22. NAME AI 3981 ot enter the mo ound of it the underlying the underlying 28c. INJ WO of PY Preet, factory, office chind ho | Carrol da of dying, su head cause given i ace of Death (Co 5 Residence JRY AT RRY RRY NO DUSE end place, end du | n Part I. Check only of SCOther Sec. 281, Long 401 | Marzul: Road U: rdiac or respi 24a. WAS AN PERFOR XX YES 2 ine) er (Specify) Escribe How in If infi Cation (Street a Cation (Street a Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) Cation (Street a) | AUTOPSY MEO? SCE SUBURY OCC. icte and Number cage (ages (mor as stated d due to the | 24b 24b 24b 27est, 24b 27err 27err 20un | Approxime Interval Be Onset and Onse | |

DHMH-16 Rev 1/89

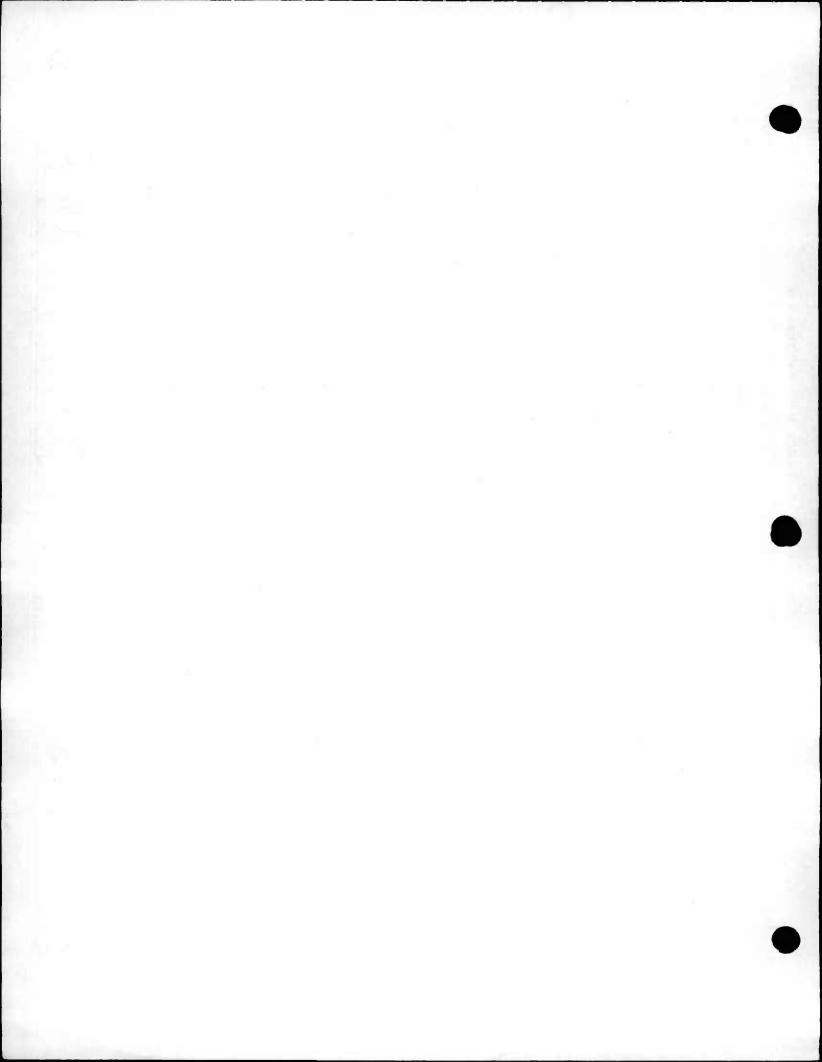


| | | FOR STATE REGISTRAR | STATE OF MARYLA | CERTIF | TMENT OF H | | MENTAL HYGIEN REG. NO | | | | |
|---|--------------|---|--|---|--|---|--|---|---|--|--|
| 2 | a | 1. DECEDENT'S NAME (First, Middle, Last) | ComeWill | iam Hai | ary Com | er, Sr. | 2. DATE OF DEATH | 1 90 | | | |
| (P | | 4. SOCIAL SECURITY NUMBER 215-16-6878 | 5. SEX 6. AGE (II | in yrs. last birthday) 77 YRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTYN (Month, Day, Year) Oct. 8,19 |)13 V | BIRTNPLACE (State or Foreign Country) 'irginia | | |
| V | 18 | 90. FACILITY NAME (If not institution, give street and number) 90. CITY, TOWN OR LOCATION OF DEATH NOTE OF DEATH NOTE OF DEATH NOTE OF DEATH NOTE OF DEATH | | | | | | | | | |
| - 1 | DIRECTOR | 10e. STATE 10b. COUNTY | | 10c. CITY, TOWN OR LOCATION Havre de Grace | | | | 10d. INSIDE CITY LIMITS? | | | |
| AND ZIZU3-3146 The hospital or attending physician detached for use as the burial-transit permit. | A A | Maryland Ha 100. STREET AND NUMBER 415 S. Market Str | rest | na\ | 101 | Lace LZIP CODE 078 | 10g. CITIZEN | 1 ★ YES 2 NO | | | |
| | BY FUNER | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | T EVER IN U.S. ARMED YES 2 NO 13. WAS DECENDED If yes, specific | | | NIC ORIGIN? (Specify Yen, Puerto Ricen, etc.) | | . RACE — American Indian, Black, White, etc. Specify: | | |
| | <u>a</u> | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5 +) | | | (Give kind of work done during most of working | | | | White BUSINESS/INDUSTRY uipment | | |
| | | 5 17. FATNER'S NAME (First, Middle, Last) Charles Guy Com | PECHAIL | | | ME (First, Middle, Maidel Emma Blev | | | | | |
| MARYL be retained by ge 5 should be | 10 B | 190. INFORMANT'S NAME (Type/Print) Jack Comer | | | | Route Number, City or To | | · · | | | |
| ALTIMORE, Reath. Page 6 may be funeral director, page | | 20s. METNOD OF CISPOSITION 1 | other place) | OF DISPOSITION (Name of cemetery, crematory or lace) 20c. LOCATION — City or Town, State Forest Hill, Md | | | | | | | |
| - m - c | a year | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE AND ADDRESS OF FACILITY HOWARD K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009 | | | | | | | | | |
| filled in by | 111, 116 | 23. PART I. Enter the diseases, or on shock, or heart failure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) | List Dnly Dne cause Dn et | sch ilns. | | | HART | | interval Between Onset and Death | | |
| b. C. BOX 131. In certificate be execute and of the private and of the private prior to burian or other traumatic. | ERTIFICATION | Sequentielly list conditions, if smy, iseding to immedists ceuse. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | | |
| ECORI requires that sen signed by of Health an | MEDICAL | PART II, Other significent condition Pulmonan Kilney 9 | | | in the underlyin | g cause given in | N AUTOPSY DRMED? 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| SICIAN: The faw certificate has be the State Dept. | PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | petient 3 DOA | 28. PLACE OF DEATH (Check only one) OTHER: 3 □ DOA 4 □ Nursing Home 5 □ Reeldence 8 □ Other (Specify) | | | | | | |
| PHYSIC this cer with th | | 27. MANNER OF DEATH 1 Netural 5 Pending | 28b. TIN | | | | Sd. DESCRIBE HOW INJURY OCCURED | | | | |
| ISIO TTEND! TOR: A after d | | 2 Accident Investigation 3 Suicide 6 Could not be 4 Nomicide determined | / — At home, term, | atreet, tactory, offic | 50 | 281. LOCATION (Street and Number or Rural Route Number, City or Yown, State) | | | | | |
| OR DIR | COMPLETED | one) | CIAN: To the best of my know | | | | | | cause(s) and manner ae stated. | | |
| 물 분 열 | BE | 2000 SIGNATURE AND TITLE OF CERTIFIES | melal | MD. | | 29c. LICENSE NU | MBER | 29d. DATE S | SIGNED (Month, Day, Yeer) | | |
| 6 6 3 | 1 0 | | O COMPLETED CAUSE OF DE | HOV RE | ch G | 2 MC | and à | 2074 | y | | |
| | | 31. DATE FILED (Month, Day, 1990) | 32. REGISTRAR'S SIGN | NATURE Son-Randel | | | | - 14 | <u> </u> | | |



ITEM:2 per DOCTOR
G-674 4/29/91 cm
FOR
1 - STATE
REGISTRAR

| _ | 2.0 | | HEGISTHAR | | CERTIFIC | CATE OF | DEATH | REG. N | 0. | | | | |
|---|---|---------------|--|---|--|---|--|--|---|--|--|--|--|
| | 1 | 1 | 1. DECEDENT'S NAME (First, Middle, Last) | A. CHAO | | 2. DATE OF DEATH 11-/-90 3. TIME OF DEATH MONTH OAY YEAR 4/00 | | | | | | | |
| 7 | (P | | 4. SOCIAL SECURITY NUMBER 265-22-7652 | 5. SEX 8. AGE (In | yrs. last birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign Country) | | | |
| 60. | should | | 9a. FACILITY NAME (If not institution, give at | reet and number) | , _ | 96. CITY, TOWN | OR LOCATION OF DE | | 9c. COUNTY | OF DEATH | | | |
| 1. Pages 1, 2, 3 | | DIRECTOR | 1200 SUNKIS | E BEACH | Kdi | Chow. | NoVILIE | | 420 | rocle.(| | | |
| | | | 10a. STATE 10b. COUNTY AL | and B(| | LO W NS | stille | md. | | 10d. INSIDE CITY LIMITS? 1 YES 2 WHO | | | |
| 200 | ransit permi | FUNERAL | | B BRACH | - | | H. ZIP CODE | | | N OF WHAT COUNTRY? | | | |
| 21203-3146 Ital or attending physician. I for use as the burial-transit | | B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | PONCEST 1 TES 2 LINE If yes, sp | | | CENDENT OF HISPAN pecify Cuben, Mexica S 2 Specify | | ea or No— 14. | s or No— 14. RACE — American Indian, Black, White, atc. Special Communication of the Communi | | | |
| 1203 | 5 | TED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 18a. DECEDENT'S U (Give kind of wo | JSUAL OCCUPATI ork done during m retired.) | ON ost of working | 16b. KIND OF B | USINESS/INDUS | TRY | | | |
| | detached for once. | COMPLET | Elementary/Secondary (9-12) | College (1-4 or 5 +) | (1/ 1 | REd | | Pir | HICLAN | \checkmark | | | |
| YLAND 2 by the hospital | be detach | BE CO | 17. FATHER'S NAME (First, Middle, Last) | ME (First, Middle, Maide | Iden Sumame) | | | | | | | | |
| MAR retained | be retained ge 5 should e notified | 10 B | THE INFORMANT'S NAME (SCHOPPING) | WRIGHT | 19b. MAILING A | ADDRESS (Street | - 1 - | loute Number, City or To | wn, State, Zip Co | | | | |
| AE, May be | | | 25s. METHOD OF DISPOSITION 1 III Sunta 2 Cremation 3 Remo | 205 | PLACE OF DISPOSIT | | CISE 3,7 | 1 200,1 | ACATION City | or Town, State | | | |
| ALTIMORE, death. Page 6 may | funeral director, page xaminer must be | | 21. SIGNATURE OF FUNERAL SERVICE LICE | | WEK 5 | RRP A | MD ADDRESS OF FAC | C+1364 J | Rockdi | M NY | | | |
| BALT after death. | 9 7 6 | \subseteq | Tussell | A. to | ik- | Las | KS Fu | NERAL | COME | - SAUSDYRY MA | | | |
| SUP | tely filled in by thation, or remo | | 23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Due TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onest and Death 12 mo | | | | | | | | | | |
| BOX 13146, icate be executed with | cian and coior to buria | ATION | Sequentielly list conditions, if any, leading to immediate cause. Entar UNDERLYING | | | | | | | | | | |
| , P.O. BC death certificate | ending If Hygie or oth | CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A C | : | | | | | | | | |
| S E | The Me | - 11 | PART II. Other aignificent conditions | contributing to deeth but | t not reaulting in | the underlyin | g cause given in I | Part i. 24a. WAS A | N AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS | | | |
| CORE | signed the Health a | FDICAL | | | | | | 1 YES | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | |
| law requ | 5 5 5 | 2 | | | | | | - | | 1 TES 2 NO | | | |
| VITAL IAN: The I | | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Che | | | | | | |
| OF VITAL | the the | ¥ I | 1 TYES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Outpet | 28b. TIME | OF 28c. IN. | IURY AT | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | | |
| | = 2 년 | BÝ | 1 Natural 8 Pending 2 Accident Investigation | INJURY WORK? M 1 YES 2 NO | | | | | | | | | |
| DIVISION OR ATTENDING | afte 23 | ETED | 3 Suicide 8 Could not be detarmined | building, etc. (Specify | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| HOSPITAL OR | | COMPLE | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC DESCRIPTION ON DESCRIPTION OF THE CHARLES OF | IAN: To the best of my knowled: On the besis of axamination a | dge, death occurred | at the time, date | end place, and due | to the cause(a) and m | anner as stated. | Buse(a) and manner as eleted | | | |
| THE HOS | TO THE FUNERAL be filed within 72 IMPORTANT: If | BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER | | 120 | 90 | 29c. LICENSE NUM | | 29d. DATE SI | GNED (Month, Day, Year) | | | |
| 01 | TO THE De filed WINDOW | 5 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEAT | TH (ITEM 27) (Type, P | Print) | D345 | 00 | | 20-90 | | | |
| | | | X Richard A. Bon | back, MD. | ,10 Wa | men k | d, Ste 1 | 10, Cocke | ysmil. | le, MD21030 | | | |
| | | U | DEC 0 3 90 | 32. REGISTRAR'S SIGNAT | | | | , | | | | | |
| | _ | | | | THE PERSON NAMED IN COLUMN 1 | | | | | | | | |



DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

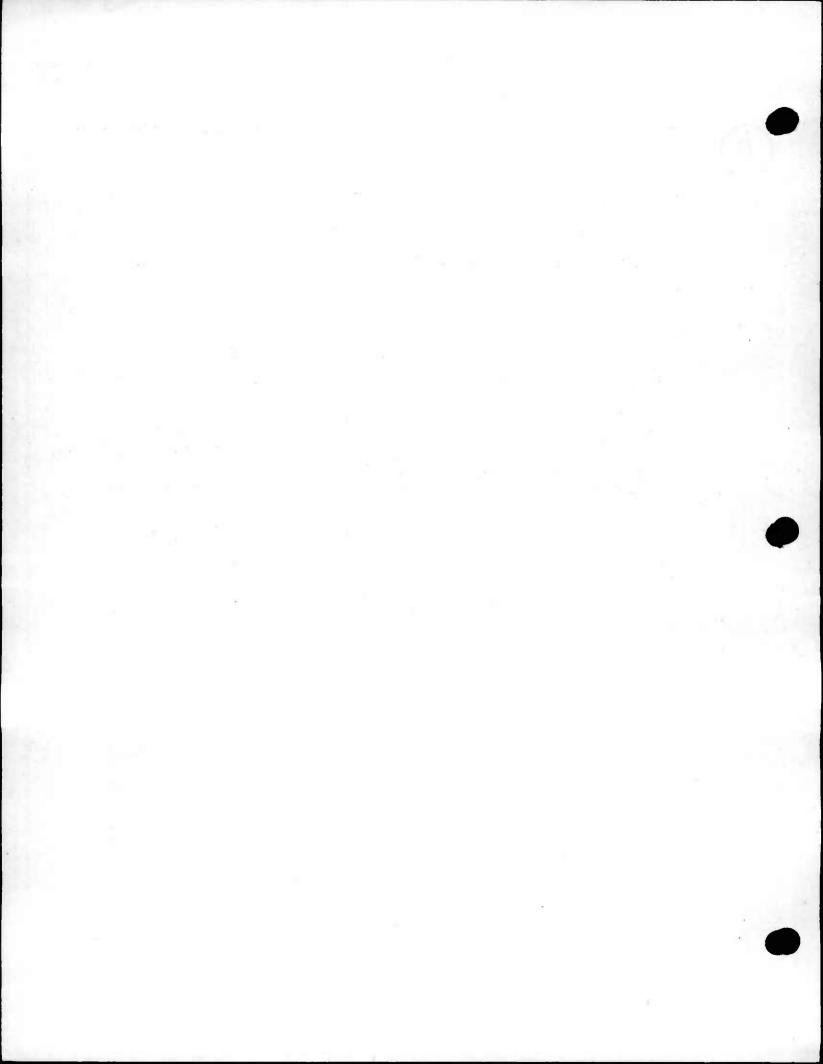
| | | t, DECEDENT'S NAME (First, | | CORBIN | | | | | | | 2. DATE O | | 1990 | YEAR | 3. TIME OF DEATH 4:05 P M |
|--|---------------|--|---|--|--|---------------------|--|---------------------|---|-------------|----------------------|----------------------------------|------------|-------------------|--|
| (P | | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 8. AGE (In) | yrs. last birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE ((Month) | Day, Year) | | 8. BIRTH Count | IPLACE (State or Foreign |
| 2 | | 212-18-634 | | 1 M 2 TF | 71 | YRS. | | | | | | 25-22 | | | MD |
| 3 should | ~ | ge. FACILITY NAME (If not in | | | | | | isb | OR LOCATI | ON OF DE | EATH | | 9c. COUN | | |
| κî | Ö | Deer's Head | | er | | | Sal | 120 | ur y | | | | WICC | AIII C | |
| Pages 1, | DIRECTOR | 10a. STATE | Wicon | | | | ry, town alis | | | | | | | | 10d. INSIDE CITY LIMITS 2 NO |
| sit permit | - 18 | 100. STREET AND NUMBER 710 Booth | | t | | | | 10 | 218 | | | | 10g. CITI | USA | WHAT COUNTRY? |
| ending physician. as the burial-transit permit. Pages 1, | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 3 Wildowed 4 Divo | | 12. WAS DECEDED FORCES? IF YES, GIVE | 1 YES | 2 NO | | If yas, s | CENDENT pecify Cub | en, Mexica | in, Puerlo F | ? (Specify Yaa ilcan, atc.) | or No | Blac | E — American Indian, k, White, atc. |
| attending ise as the | 유 | 15. DEC | CEDENT'S EDU | CATION completed) | 1 | I6e. OECEOENT'S | S USUAL C | CCUPATI during m | ION lost of work | ing | 16b. | KIND OF BUS | SINESS/INC | DUSTRY | |
| should by the hospital or att should be detached for use vifiled at once. | COMPLETED | Elamentary/Secondary (| | Collage (1-4 or 5 | +) | life. Do NOT i | tind of work done during most of working NOT use retired.) | | | | | | | | |
| nospit iched | MP | 12 | | None | | Demos | tic | Work | _ | rilemin Ali | NAC (El-A (| fiddle, Meiden | Cumamal | | |
| be detach | | 17. FATHER'S NAME (First, M | | | | | | | | | | ella D | | n Do | rri a |
| ed by | BE | Issiac H. | | | . | 19b, MAILIN | G ADDRES | S (Street | | | | er, City or Tow | | | ATS |
| 2 2 | 유 | Roy Davis 735 N. Westover Dr | | | | | | | | | | | | | |
| may be or, page | | 20ar METHOO OF DISPOSIT | TION | | 20b. I | PLACE OF DISPO | OSITION (A | eme of c | emetery, cre | matory or | - | 20c. LO | CATION - | City or T | own, State |
| e 6 ma ector, p | | 4 Donation 5 Othe | | novali from State | | Spring | | | | | | Sa | lisbų | ıry | |
| death. Page e funeral dired I. examiner n | | 21. SIGNATURE OF FUNER | | | | | 22 | | AND AOOR | | | | | | 1-1 |
| | | ▶ Russell | l Fook | 3; | | | - | Toks | - 7 | 14 | 761 | B15 | 74. | SAL | isbury, mdi |
| executed within 24 flours after of and completely filled in by the o burial, cremation, or removal matic event, the medical | | | resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| th certificate be execuending physician and Il Hygiene prior to bur or other traumati | CERTIFICATION | Sequentially liet conditions, If any, leading to immediate ceues. Enter UNDERLYING CAUSE (Disease or injury thet initieted events resulting in death) LAST b. Spatus Post Fracture of right hip Due To (OR AS A CONSEQUENCE OF): c. Decubiti ulcer at base of spine OUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | | | | | | | |
| | | PART ii. Other signific | | | | it not resulting | g in the u | ınderiyl | ing ceues | given ir | n Pert i. | 24a. WAS AF | N AUTOPSY | 24 | b. WERE AUTOPSY FINOINGS AVAILABLE PRIOR TO |
| requires that the dear been signed by the att | : MEDICAL | Cevebrovascular Accident 1 YES 2 NO NO NO NO NO NO NO NO NO NO | | | | | | | | | OF DEATH? | | | | |
| The law requate has been ate Dept. of lem 23 sho | SICIAN: | 25. WAS CASE REFERRED | TO MEDICAL | | | | | | PLACE OF | OEATH (C | Check only o | ne) | | | |
| SICIAN: The certificate h the State I , or Item | SIC | EXAMINER? | | HOSPITAL: | ☐ ER/Outpa | itlant 3 🗆 OOA | OTHI | | ome 5 🗆 | Raaldence | 8 🗆 Oth | r (Specify) | | | |
| 美麗華 9 | ву рну | 27. MANNER OF OEATH CAN Natural 5 Accident | Pending Investigation | | OF INJURY Day, Year) | 28b. T | IME OF INJURY M | 1 | NJURY AT WORK? YES 2 | □ NO | 28d. DE | SCRIBE HOW | INJURY O | CCURED | |
| TTENDII TTOR: A after de 28 Is | TED | | Could not be determined | 28a. PLACE | OF INJURY og, etc. (Speci | — At home, fern | n, atreet, te | ectory, of | fica | | | CATION (Street or Town, State | | er or Rurs | I Route Number, |
| 2 2 2 5 | COMPLE | CONSCR ONLY | | | ne beat of my knowledge, death occurred at the time, data and piece, and beels of axamination and/or investigation, in my opinion, death occured at | | | | | | | | and due to | the ceus | |
| TO THE HOSPITA TO THE FUNERA Be filed within 7 IMPORTANT: I | TO BE (| 290. SIGNATURE AND TITLE OF CENTIFIER | | | | | | | 29d. LICENSE NUMBER 29d. OATE SIGNEO (Menth. Day. Year) | | | | | | |
| | | Benito S. | | | | | | ive, | Sal | isbu | iry, I | 1d. 2 | 1801 | | |
| | 3 | 31. DATE FILEO (Month, De | ly, Year) | | | ATURE Pande | | | | - | | | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

in a consecutive at a second consecutive and a

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | | CERTIF | ICATE OF | DEATH | REG. NO |). | | | |
|--|---|--|---------------------------------|---|--|--|----------------------|--|--|--|
| | 1. DECEOENT'S NAME (First, Middle, Last) | C | ZAPK | IFW | CZ | POUT 30 | 1990 | R 3. TIME OF DEATH A 125 M | | |
| (P) | 4. SOCIAL SECURITY NUMBER | 1 XM 2 - F | (in yrs. last birthday) VRS. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 4-14-19 | 25 MA | RTHPLACE (State or Foreign ountry) RYLAND | | |
| 1, 2, 3 mg | 9e. FACILITY NAME (If not institution, give PENINSULA GENERAL RESIDENCE OF DECEDENT | | | | SBURY, M | | 9c. COUNTY O | | | |
| Pages | 100. STATE 10b. COUNT MD. WIC | OMICO | | Y, TOWN OR LOCA LISBURY | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| yslcian. urial-transit permit. FUNERAL D | LOT 12C, NAYL | | | | 21801 | | U.S.A | | | |
| 5 5 | 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 XYES IF YES, GIVE WAR OR O WW II AF | 2 NO | If yea, ap | CENDENT OF HISPAI DECITY Cuban, Mexica C 2 NO Specif | NIC ORIGIN? (Specify Year, Puerto Ricen, atc.) fy: | E | ACE — American Indian, Slack, White, etc. Specify: WHITE | | |
| ital or attending for use as the LETED BY | Elementary/Secondary (0-12) | UCATION le completed) Collège (1-4 or 5 +) | (Give kind of life, Do NOT u | 186. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) AUTO MECHANIC REPAIR AGENCY | | | | | | |
| by the hospital be detached to at once. | | PKIEWCZ | AULU . | MECHANI | | AME (First, Middle, Maide | n Sumame) | CI | | |
| 5 should TO BI | 10. INFORMANT'S NAME (Type/Print) | | | as 10 | | Route Number, City or To | | 9) | | |
| leath. Page 6 may be funeral director, page xaminer must be a | 20e_METHOD OF DISPOSITION 1 ABurial 2 Cremeter 3 Gree 4 Donation 5 Green Specify | moval from State | b. PLACE OF DISPO | | metery, crematory or TERY | | OCATION — CITY O | ANNE, MD. | | |
| death. | 21. SIGNATURE OF THE RAIL SERVICE I | ICENSEE SO | und | | DS FUNE | CRAL HOME | , SALIS | BURY, MD. | | |
| within an iours at the the time of the temperation, or remerent, the medical cent, the medical cent. | disease or condition resulting in death) 8. DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| certificate be execute fing physician and co ygiene prior to buria other traumatic TTIFICATION | | | | | | | | | | |
| equires that the dea en signed by the at of Health and Meniz hows any injury, MEDICAL C | PART ii. Other aignificent condition | ons contributing to deeth | but not resulting | in the underlying | ng cause givan in | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF OEATH? 1 YES 2 NO | | |
| AN: The law requinificate has been si State Dept. of He r item 23 show | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | Instinct 3 DOA | OTHER: | PLACE OF OEATH (C | heck only one) | | | | |
| this certi with the rked, or | 27. MANNER OF DEATH | 26e. OATE OF INJURY (Month, Day, Year) | 28b, TI | ME OF 28c. IN | JURY AT ORK? YES 2 NO | 28d. OESCRIBE HOV | V INJURY OCCUR | ED | | |
| OR ATTENDING PHYS DIRECTOR: After this of hours after death with item 28 is marked | 3 Suicide 8 Could not b | 28a PLACE OF INJUR | Y — At home, farm | , street, fectory, off | ice | 28t. LOCATION (Stree City or Town, Sta | | tural Route Number, | | |
| | 29e. CERTIFIER 1 CERTIFYING PHY | SICIAN: To the best of my kno NER: On the beels of examinati | | | | | | use(e) and manner ea stated. | | |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 IMPORTANT: If | 296. SIGNATURE AND TITLE OF CERTIF | 4 10 | | | 29c, LICENSE NI D 20 4 | | 29d. OATE SI | GNEO (Month, Day, Year) 2/3-90 | | |
| | J.L. Z | PAFFET | 10 | De, Print) | 57 | | | | | |
| 1+17 | DEC 0 3 '90 | 32. BEGISTRAR'S SIG | NATURE Jon-Randell | 2 | | | | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 4 |
|--|
| THE HOSPITAL OR ATTRIBUTE PHYSICIAN I The law requires that the deam certificate be executed within 42 but since bearing the established for strength of physician in the control of the c |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARY | LAND / DEPARTM CERTIFIC | | | MENTAL HYGIEN | | |
|---|--|--|-------------------|----------------------|---|------------------|--|
| 1. DECEDENT'S NAME (First, I | Widdle, Last) | | 0 | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| JOHN | | | ocr | on, Jr. | November | | 7EAR 1836 M |
| 4. SOCIAL SECURITY NUMBER | R 5. SEX 6. AG | E (In yrs. last birthday) | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 8. | BIRTHPLACE (State or Foreign |
| 214-10-97 | | | INTHS DAYS | HOURS MIN. | 10-16-190 | 4 | Country) Pa. |
| 9a. FACILITY NAME (If not ins | 000 | | CITY TOWN | OR LOCATION OF DE | <u></u> | | Y OF DEATH |
| | CNERAL HOSPITAL | | SALISI | | 28111 | | OMICO |
| RESIDENCE OF DECI | | | SALISI | JUKI | | MICO | JIIICO |
| | 10b. COUNTY | 10c. CITY, T | OWN OR LOCA | TION | | | 10d. INSIDE CITY |
| Md. | Wicomico | De1 | mar | | | | LIMITS? |
| 10e. STREET AND NUMBER | WACOMACO | | | f. ZIP CODE | | 10g CITIZE | N OF WHAT COUNTRY? |
| | 5069 Foskey Lane | | 1" | 218 | 75 | USA | N OF WIRI COOKINI? |
| | | | | | | | 2022 |
| 11. MARITAL STATUS 1 Never Married 2 1 | 12. WAS DECEDENT EVER | RINUS ARMED | If yes, sp | pecify Cuban, Mexica | NC ORIGIN? (Specify Ya In, Puarto Rican, alc.) | a or No— 14 | RACE — American Indian, Black, White, atc. |
| 3 X Widowed 4 Divor | I IF YES, GIVE WAR OR | DATES | 1 TYES | S 2 NO Specifi | y: | | White |
| | n _u | 1 | | | | | |
| | DENT'S EDUCATION highest grade completed) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use n | done during m | ON ost of working | 16b. KIND OF BU | ISINESS/INDUS | STRY |
| Elamentary/Secondary (0- | (2) College (1-4 or 5+) | A | | | | - 1 | |
| 6 | | Pump Te | ester | | Dresser | Indus | stries |
| 17. FATHER'S NAME (First, Mic | Idle, Last) | | | 18. MOTHER'S NA | ME (First, Middle, Maider | Surname) | |
| John Cocron | | | | Margare | t Boquell | Cocror | ı |
| 19a. INFORMANT'S NAME (Ty) | pe/Print) | 19b. MAILING AL | ODRESS (Street | and Number or Rural | Aoute Number, City or To | vn, State, Zip C | ode) |
| John Cocron | III | 104 Pi | ne St. | Delmar. | Md. 21875 | | |
| 20a. METHOD OF DISPOSITIO | | 20b. PLACE OF DISPOSITI | | | | | ty or Town, Stata |
| 1 X Buriel 2 Cremation 4 Donation 5 Other | 3 Ramoval from State | St. Stepher | | | . 1 | lmar, | |
| 21. SIGNATURE OF FUNERAL | | oc. ocepher | | ND ADDRESS OF FA | | · Imar , | DC. |
| 11 | 1//- | , / | | | Home, Inc | | |
| Willer | in M. ARM | | | r, De. 1 | | • | |
| 23. PART I. Enter the dis | naasea, or complications that cause or | sed the death. Do not | entar tha me | oda of dylng, auc | h aa cardlac or resp | lratory arres | at, Approximata Interval Batwaan |
| IMMEDIATE CAUSE (Final | | | 1 | | | | Onsat and Daath |
| disassa or condition | Car | dio-Pu | mu | nauz | Anvest | | |
| resulting in death) | DUE TO (OR A | S A CONSEQUENCE OF): | | - | | | |
| | Ca | , Luna | | | | | |
| Sequentially list condition | | S A CONSEQUENCE OF | , | | | | |
| If any, leading to immed cause. Enter UNDERLYIN | | · · | | | | | |
| CAUSE (Diseasa or Injur | y C. DUE TO (OR A | S A CONSEQUENCE OF): | | | | | |
| that initiated avents resulting in death) LAST | | | | | | | |
| | d | | | | | | |
| PART II. Other algnificar | t conditions contributing to deat | h but not resulting in | the underlyin | ng cause given in | | | 24b. WERE AUTOPSY FINDINGS |
| C | wnany av | roun D | 15000 | De. | | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | Id MI A | 1 | | | 1 _ YES | 2 NO | DF DEATH? |
| | 0 0 5 | | | | — | | 1 TYES 2 NO |
| | th. | | | | | | |
| 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL HOSPITAL: | , | 26. F | PLACE OF DEATH (C/ | neck only one) | | |
| 1 TYES 2 NO | 1 Inpatient 2 ER/C | | | me 5 🗆 Residence | 6 Other (Specify) | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJUI (Month, Day, Yes | | | JURY AT ORK? | 28d. DESCRIBE HOW | INJURY OCCU | RED |
| | Pending nvestigation | | | YES 2 NO | | | |
| 2 Destable | 28a. PLACE OF INJU | JRY — At home, farm, str | et, factory, offi | ice | 281. LOCATION (Stree | and Number of | r Rural Route Number, |
| | Could not be building, atc. (Salarmined | Specify) | | | City or Town, State | 9) | |
| 29a. CERTIFIER | | | | | 4.1 | | |
| (Check only | FYING PHYSICIAN: To the best of my kr | Δ. | | | | | |
| 2 MEDI | CAL EXAMINER: On the basis of susmini | and/or investigation, | In my opinion, | death occured at the | lime, data and place, | ind dua lo lha | cause(a) and manner as stated. |
| 29b. SIGNATURE AND TITLE | OF CERTIFIER | | | 29c. LICENSE NU | MBER | 29d. DATE | SIGNED (Month, Day, Year) |
| | (1) | | | D2503 | 6 | > 1 | 1123190. |
| 30. NAME AND ADDRESS OF | PERSON WHO COMPLETED CAUSE OF | DEATH (ITEM 27) (Type, P | -021) . | | | ALIS | BUNY. MW |
| 31. DATE FILED (Month, Day, | | *** | | | | | |
| HOV JA | 10 1000000 | war-Madan | | | | | |

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| | REGISTRAR CERTIF | ICATE OF | DEATH | REG. NO. | | | | | | | |
|---------------|--|-------------------------------------|-----------------------------|---|-----------------|--|--|--|--|--|--|
| , | 1. DECEOENT'S NAME (First, Middle, Last) Laura M. Cech | | | 2. DATE OF DEATH DAY | | 3. TIME OF DEATH | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 2/5-/4-8527 1 - M 2 X F Yrs. | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) SEPT. 15, | - | HPLACE (State or Foreign | | | | | |
| TOR | 9s. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital RESIDENCE OF DECEDENT | 96. COUNTY OF DEATH Baltimore City | | | | | | | | | |
| DIRECTOR | 10s. STATE 10b. COUNTY 10c. CIT | Y, TOWN OR LOCATI | ON | | | 10d, INSIDE CITY LIMITS? 1 YES 2 NO | | | | | |
| FUNERAL | 8195. ELLWOOD AVE. | 10f. | 21224 | | 10g. CITIZEN OF | WHAT COUNTRY? | | | | | |
| B | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES | | | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) Bookeper Bookeper This DECEDENT'S SUSUAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.) This DECEDENT'S URAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.) This DECEDENT'S URAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.) This DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT uge retired.) | | | | | | | | | | |
| BE CO | TULIUS PALINOLOKI | / | UL | ME (First, Middle, Maiden S | U | | | | | | |
| ٥ | STEPHEN J. CECH SR. 819 | S. ELL | WOOD | AUE · Z | BALTO. | MD. 2/224 | | | | | |
| | 20s METHOD OF DISPOSITION 1 Surial 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) | TANISL | ous CE | M. BA | HTO. C | 1.5 | | | | | |
| | 21. SIGNATURE OF RIMERAL SERVICE LICENSEE | SKAR | | 4. 2829/ | | 21224 | | | | | |
| | 23. PART I. Enter the disagrees, or complications that caused the death. Do abock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) ■ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ □ | ine | da of dying, such | n sa cerdiec or reaple | ratory smest, | Approximate interval Between Onset and Death | | | | | |
| CATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO FOR AS A CONSEQUENCE OF): CANADA CONSEQUENCE OF): PRODUCT OF THE PRODUCT OF TH | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated evente resulting in death) LAST | | | | 20 years | | | | | | |
| EDICAL | PART II. Other significant conditions contributing to death but not resulting | In the underlying | g cause given in l | Part i. 24e. WAS AN. PERFOR 1 50 YES 2 | MED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 No 1 No Input lent 2 ER/Outpatient 3 DOA | - | ACE OF DEATH (Che | ock only one) 6 To Other (Specify) (A) | m Mus | would Horp. | | | | | |
| BY PHYS | 27. MANNER OF DEATH 1 Netural 8 Pending 28s. DATE OF INJURY (Month, Day, Year) 18 | 28d. DESCRIBE HOW II | | 10.47 | | | | | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be detarmined 28a. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) No In My Thus luck! 28a. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | | | | |
| COMPLETED | 29a. CERTIFIER (Check only orie) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CERTIFIER RY HUMBER WAS ASSESSED OF PERSON WHO COMPLETED CALLER OF PEACH SITEM AND COMPLETED CALLER OF PEACH SITEM AND COMPLETED CALLER OF PEACH SITEM AND COMPLETED CALLER OF PEACH SITEM AND | | 29c. LICENSE NUM | /A | 29d. DATE SIGNE | (Month, Day, Year) | | | | | |
| | III WII NAME AND ADDRESS OF PERSON WHO COMBI ETEX CALISE OF REATH (ITEM 57) /T | A Chelenti | | | | | | | | | |

Union Memorial Hospital

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 28-mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bund-transit permit. Pages it be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

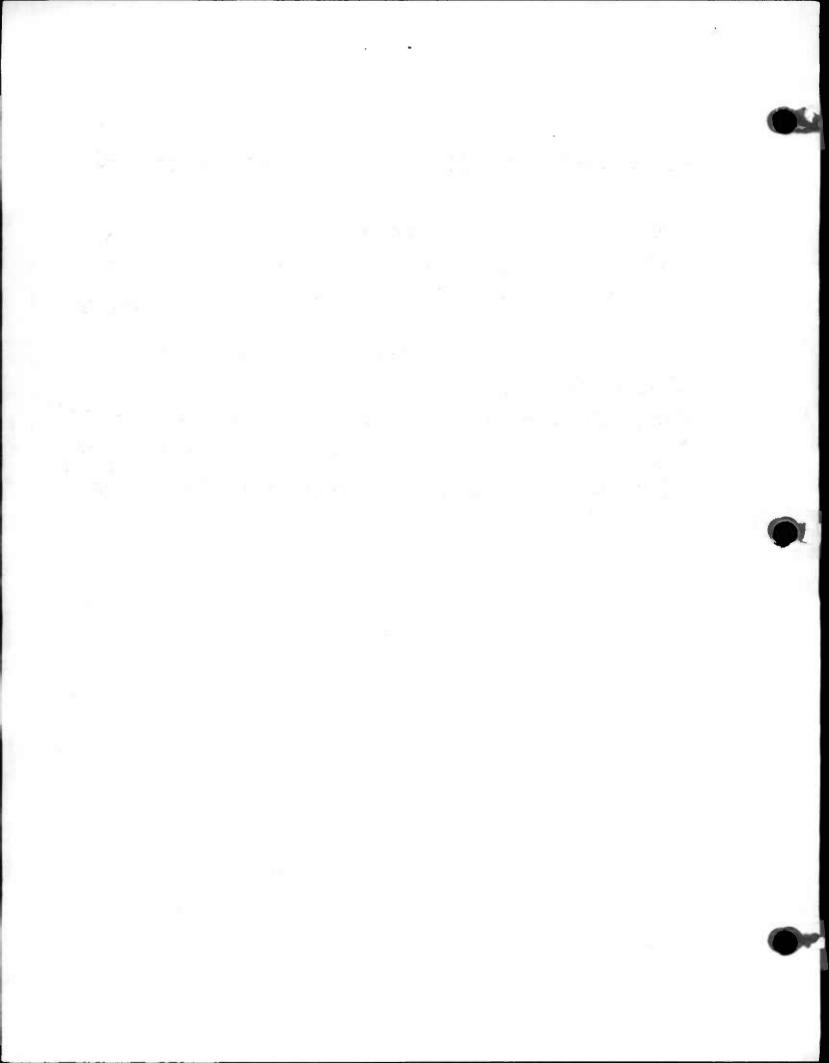
IMPORTANT: If them 28 is marked, or them 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

7. Chard Y. H. N. Low M. D. 31. DATE FILED (Month, Day, Year)
NOV 2 8 '90

DHMH-18 Rev 1/89



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| AL MECORDS, P.O. BOA 13146, | he law requires that the death certificate be executed within zo nours after death. Page 6 may be retained by the hospital or attending physician. | has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit p | begr. of hearth and mental hygiene prior to burial, cremation, of removal. |
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injury, or other traumatic event, the medical examiner

Item 23 shows any

COMPLETED

BE 2

certificate h h the State I d, or Item this cu 28 is marked, BY

After OR ATTENDING DIRECTOR: /

TO THE HOSPITAL OR ATT TO THE FUNERAL DIRECT be filed within 72 hours at IMPORTANT: If Item 2

FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF OEATH 90 YEAR 3. TIME OF DEATN 22^{DAV} 11 9:10 A Edgar Cole Jerry 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign MONTHS DAYS HOURS Maryland 213.36.6239 1 € H 2 🗌 F YRS Aug. 14. Se. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY, TOWN OR LOCATION OF DEATH Elkridge Northbound 195 DIRECTOR Howard RESIDENCE OF DECEDENT 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel Linthieum 1 YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1319 Furnace Road 21090 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 14. RACE — American Indian, Black, White, etc. 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-If yes, specify Cuben, Mexican, Puerto Rican, etc.)

1 YES 244 NO Specify: 1 Never Married 2 Married Specify: White IF YES, GIVE WAR OR DATES B 3 Widowed 4 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondery (0-12) Network System Technician T & TA 12 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Sumame, Grace M. Swope Thomas B. Cole BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number. City or Town, State, Zip Code) 2 Patricia A. Cole 1319 Furnace Road, Linthicum, Md. 2017 METHOD OF DISPOSITION
1 Burial 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State Meadowridge Mem. Park Elkridge, Maryland 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSER 22. NAME AND ADDRESS OF FACILITY
Gary L. Kaufman Funeral Home 15000 las 5695 Main Street Elkridge, Md. 21227 23. PART I. Enter the disease es, or complications thet caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or hasn fellure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset end Death . Hypertensive Arteriosclerotic Cardiovascular Disease resulting in death) CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF): if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated event resulting in death) LAST PART II. Other significant conditions contributing to desth but not resulting in the underlying cause given in Part I. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE 24a. WAS AN AUTOPSY PERFORMED? MEDICAL 1 X YES 2 NO OF DEATH? 1 X YES 2 NO PHYSICIAN:

| 25. WAS CASE REFERRED TO MEDIC | AL | 26. PLACE OF DEATH (Check only one) | | | | | | | | | |
|--|------------------------------------|---|---------------------|---------------------------------|--|----------------|--|--|--|--|--|
| 1 VES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Out | HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA | | | 5€ Other (Specify) SCENE | (See 9A above) | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investig | | 28b. Tr | ME OF IJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. OESCRIBE HOW INJURY OCCUREO 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | |
| 3 Suicide 6 Could n 4 Homicide determin | | Y — At home, farm, scify) | street, fac | tory, office | | | | | | | |
| one) | | | | | e to the cause(a) end manner as sta | | | | | | |

| 99a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data one) 2 MEDICAL EXAMINER: On the bests of axamination and/or investigation, in my opinion, data | | |
|--|---------------------------|---|
| Nonalle & Wight M.D. For | 29c. LICENSE NUMBER CCME | 29d. DATE SIGNED (Month, Day, Year) ▶ 11/22/90 |

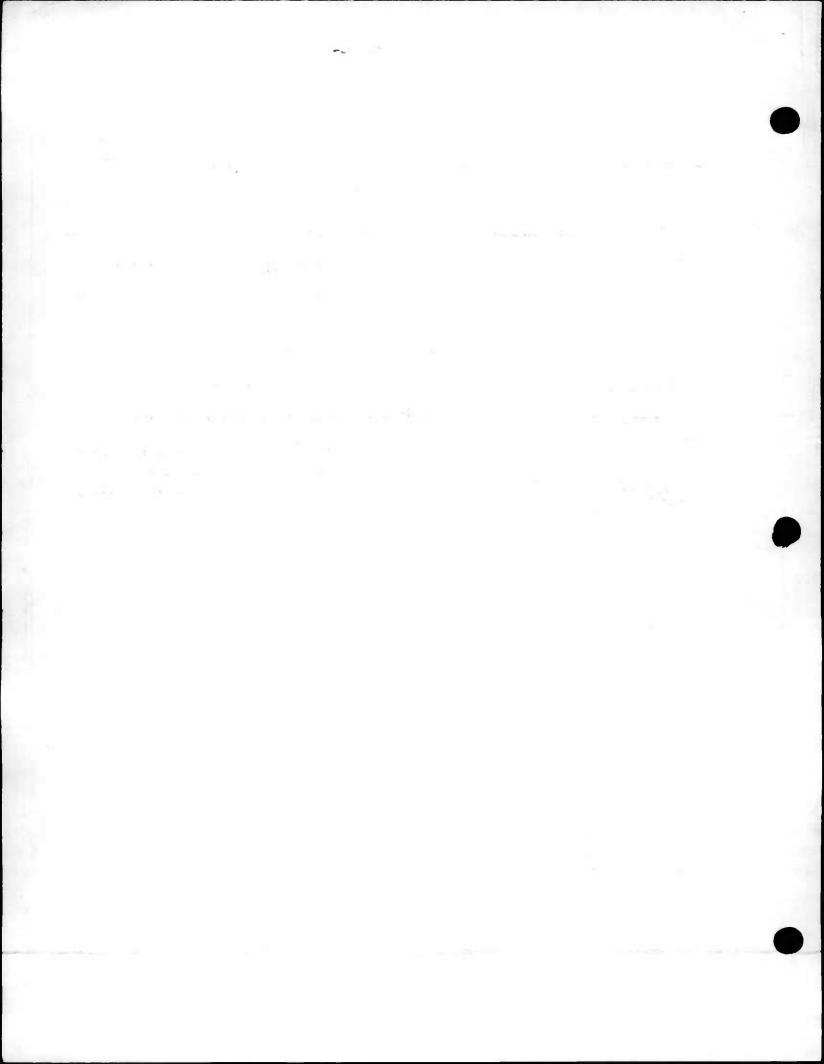
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

NUV 26 '90

| | Frank J. Peretti, | | 111 | Penn | St. | Baltimore, | Md. | 21201 |
|----|---------------------------------|---------------------------|-----|------|-----|------------|-----|-------|
| 31 | . DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | | | | |

whia Davidson-Randall

0



Approximate interval Between **Onaet end Deeth**

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?

187/2

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| 21203-31 | Total of |
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1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

2

| | | 1. OECEDENT'S NAME (First, Middle, Lat | | Mary | P. Col | llie | | | 2. DAT MON | E OF DEATH | AY | YEAR | 3. TIME OF OEATH |
|---|---------------|--|---|----------------|-------------------------|--------------------|------------|---|--|---------------------------------------|------------|---|--|
| | | 4. SOCIAL SECURITY NUMBER 230-07-8311 | 5. SEX 1 M 2 F | | rs. last birthday) YRS. | IF UNDE | R 1 YEAR | IF UNDER 24 HI HOURS MI | (4.4. | E OF BIRTH oth, Day, Year) | | 8. BIRTHP Gountry) | LACE (State or Foreign |
| 1,2, | STOR | 9a. FACILITY NAME (If not institution, give FREDERICK HE) RESIDENCE OF DECEDENT | e street and number) | CE | NTER | 9b. CIT | | OR LOCATION O | OF DEATH | 11-01 | 9c. COUN | | ath PICK |
| it. Pages | DIRECTOR | Maryland Ho | ward | | | ty, town Lumb i | | TION | | | | | 10d. INSIDE CITY LIMITS? |
| phystcian. bufial-transit permit, Pages | FUNERAL | 6341 Route 29 | | | | | 10 | 1. ZIP CODE 21046 | | | | S.A. | HAT COUNTRY? |
| I or attending or use as the | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS OECEDEN FORCES? 1 IF YES, GIVE W | YES 2 | . NO | 13. | If yes, sp | CENDENT OF HI Decity Cuban, Ma 3 2 NO S | SPANIC ORIG exicen, Puerto pecify: | iN? (Specify Yes o Rican, atc.) | | 14. RACE | American Indian, White, atc. |
| | COMPLETED | 15. DECEDENT'S El (Specify only highest gra Elementary/Secondary (0-12) | OUCATION de completed) College (1-4 or 5 d | | Iffe. Do NOT L | work done | during me | ON ost of working | 18 | Safewa | | | 77 6 A 4 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 |
| by the hospita be detached 1 at once. | E CON | 17. FATHER'S NAME (First, Middle, Last) James Henry | | | | | | | | Middle, Malden | | | |
| ector, page 5 should must be notified | TO BI | 19a. INFORMANT'S NAME (Type/Print) Mr Jim Collie | | | | | | Blanche Douglas Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 Columbia Md 21046 | | | | | |
| | | 20a. METHOD OF DISPOSITION 1 | moval from State | Oth | ACE OF DISPO | SITION (N | ame of ce | metery, crematory | or Mo | 20c. LO | CATION — C | | |
| death. Page e funeral dire ul. | | 21. SIGNATURE OF FUNERAL SERVICE | H. WIZ | the s | etro C | 22 H | NAME A | H Wit: | zke Fu | meral | Home | Inc | Maryland |
| executed within 24 and completely filling burial, cremation matic event, the | NOI | IMMEDIATE CAUSE (Final disease or condition resulting in death) Due TO (on as a consequence or): Sequentielly list conditions, Due TO (on as a consequence or): | | | | | | | | | | Approximate interval Betwee Onset end Dec | |
| th certificat ending phy I Hygiene p or other | CERTIFICATION | if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | cDUE TO | OR AS A CO. | NSEQUENCE O | OF): | | Heart | De | ine | | | |
| | : MEDICAL | PART II. Other eignificent conditi | one contributing to | death but r | not resulting | in the u | nderiyin | g ceuse giver | in Part i. | 24a. WAS AN PERFOR 1 YES 2 | MED? | 0 | WERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law TO THE FUNERAL OIRECTOR: After this certificate has be filed within 72 hours after death with the State Dept. IMPORTANT: If item 28 is marked, or item 23 | PHYSICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | nt 3 🗆 DOA | OTHE 4 K Nu | R: | LACE OF DEATH | | | | | |
| After this ce death with t marked, | ВУ | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a BLACE O | ay, Year) | | JURY | 1 🔲 | YES 2 NO | | SCRIBE HOW I | | | |
| OR ATTENO OVRECTOR: A hours after d item 28 is | ETED | 3 Suickle 8 Could not b 4 Homicide determined | bullaing, | etc. (Specify) | At home, farm, | | | | City | CATION (Street a y or Town, Stete) | | | ute Number, |
| OSPITAL OUNERAL OUNERAL OUNTRIN 72 ho | COMPL | (Check only one) 2 MEDICAL EXAM | SICIAN: To the best of NER: On the basis of as | | | | | | | | | | and menner as stated. |
| TO THE HOSPI TO THE FUNEF be filed within IMPORTANT: | O BE | 296. SIGNATURE AND TITLE OF CERTIF | S. Non | olv | 1 | | | 29c. LICENSE | NUMBER | , | | | Month, Day, Year) |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

morros a p.

32. REGISTRAR'S SIGNATURE

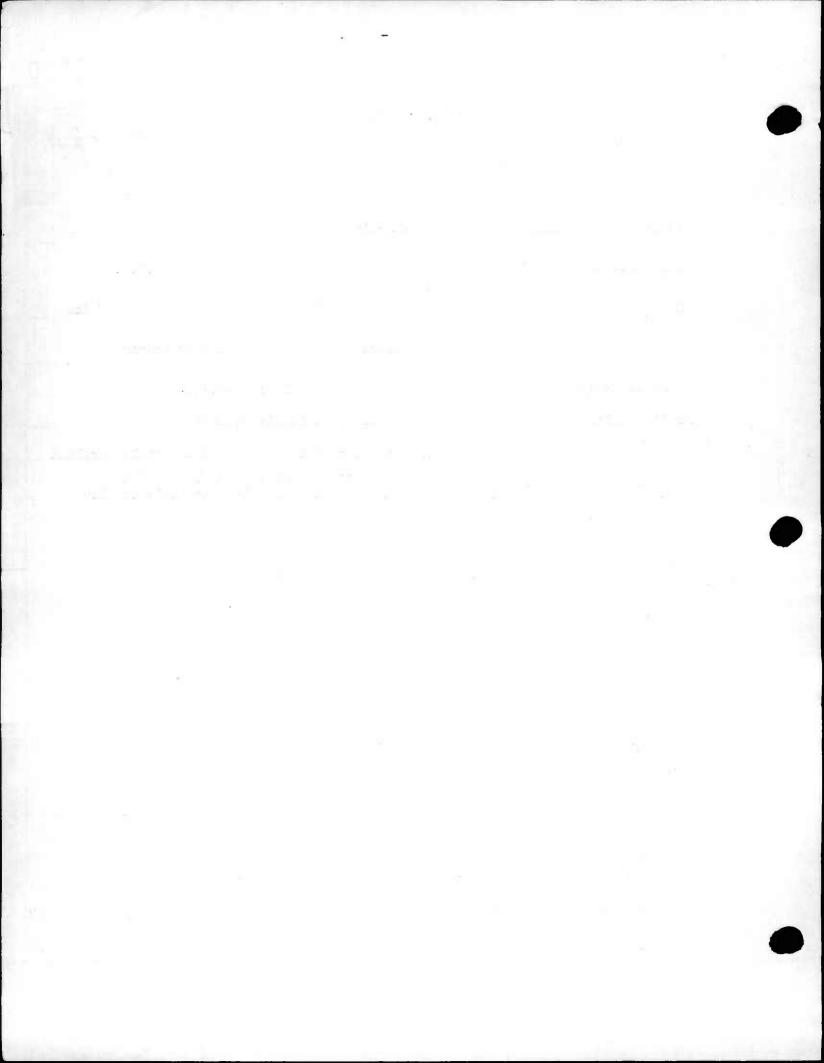
Win Vavidson-Bindage

Butther G.

31. DATE FILED (Month, Day, Year)

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE **CERTIFICATE OF DEATH**

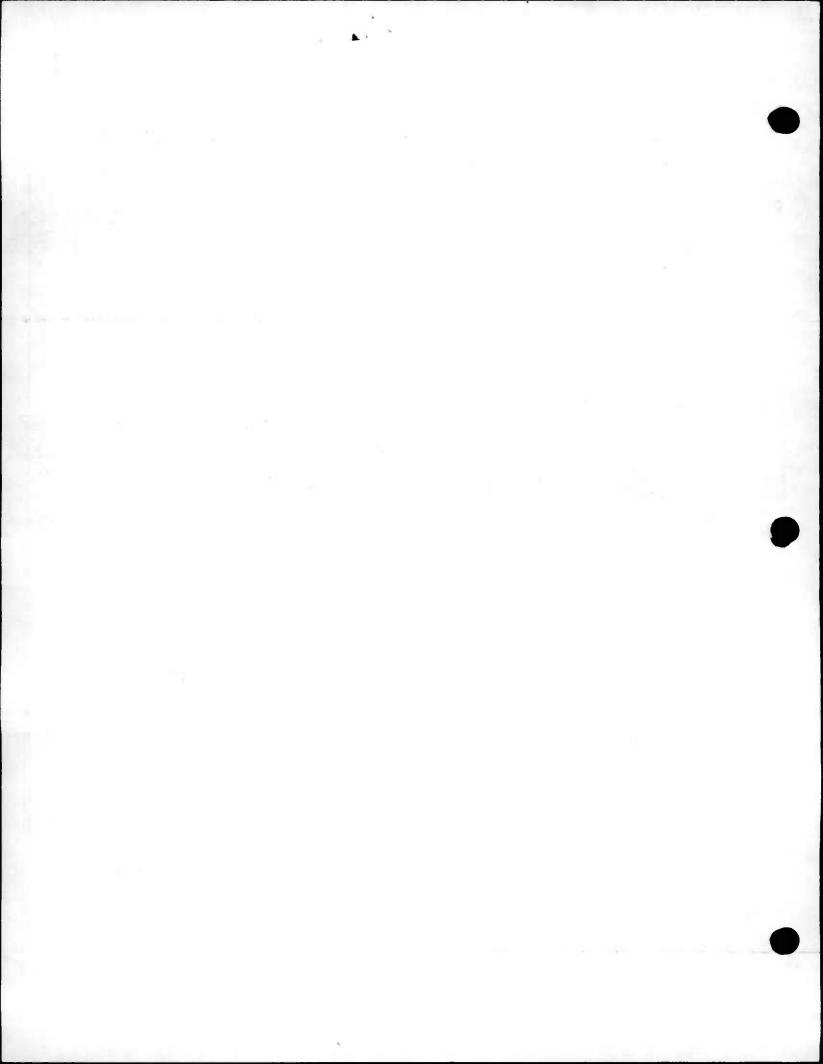
DHMH-16 Rav 1/89



| DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a month of the completely filled in by the funeral director, page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | |
|---|--|
|---|--|

| | 1 - FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL HYGIEN | _ | | |
|-----------------|--|---|--|--|---|---|-------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Thomas Ear | -1 | | | | 2. DATE OF DEATH DO | AY YEA | | |
| | 4. SOCIAL SECURITY NUMBER 406-60-4214 | 5. SEX 6. AGE (In | YRS. MO | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | December 7. DATE OF BIRTH (Month, Day, Year) 10/22/43 | WV | | |
| OR | 9e. FACILITY NAME (If not Institution, give st Memorial Hospita | | 91 | Cumber | r Location of DE. | АТН | Allega: | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY WV Hamp | | | OWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | |
| FUNERAL | 10. STREET AND NUMBER Rt. 1, Box 638 | | | 101 | 26757 | | 10g. CITIZEN | OF WHAT COUNTRY? | |
| B≼ | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 15 YES IF YES, GIVE WAR OR DAY | U.S. ARMED 2 NO TES | If yee, spe | ENDENT OF HISPAN | IIC ORIGIN? (Specify Yea n, Puarto Rican, alc.) | n or No 14. F | RACE — American Indian, Black, White, atc. Specify: Hite | |
| PLETED | 15. DECEDENT'S EDUC (Specify only highest grade Elamentary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S US (Give kind of work life. Do NOT use re Storero | done during mo tired.) | st of working | 16b. KIND OF BU | | | |
| BE COMPLET | 17. FATHER'S NAME (First, Middle, Last) Richard Carte | r | | | 18. MOTHER'S NAI | ME (First, Middle, Maldon a E. Polar | Sumame) | | |
| TO B | Bonnie Jean Cart | | Rt. 1, | Box 63 | 8, Romne | Route Number, City or Tow Y, WV 26 | 757 | | |
| | 20e. METHOD OF DISPOSITION 1 Buriel 2 Cremation 3 Remo | oval from Stata | other place) Ebenez | zer Cem | etery | Ro | omney, | WV | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC Saud J. 1 | Mrgul | | 230 | E. Main | ST., Romne | ey, WV | al Home, Inc. 26757 | |
| CERTIFICATION | | a. DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): | Interval E Onest an SEQUENCE OF: LUCOULCE OF: LUCOULCE OFO: SEQUENCE OFO: With Exacerbation SEQUENCE OFO: | | | | | |
| CAL | that initiated events reaulting in daeth) LAST PART II. Other aignificent condition | g cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | |
| PHYSICIAN: MEDI | | | | | | 1 🗇 YES : | 2 (D-410 | OF DEATH? | |
| IYSICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | atlent 3 DOA 4 | THER: | | 8 Other (Specify) | | | |
| BY | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 8 Could not be | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C INJUR | M 1 | PRK? YES 2 NO | 28d. DESCRIBE HOW 28f. LOCATION (Street | and Number or R | | |
| COMPLETED | 4 Homicide determined | building, etc. (Speci | | at the time, date | end place, end due | City or Town, State | | | |
| | anal | R: On the basis of examination | | | | time, data and place, a | ind due to the ce | use(s) and manner as stated. SNED (Month: Day, Year) | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WH | Sy | ATH (ITEM 27) (Nos. Pr | int) | D35 | 481 | ► 1Z | /2/90 | |
| | Dr. Sagin Memoria | al Hospital & | Medical | | Cumberla | nd, MD 21 | .502 | K T | |

DHMH-18 Rev 1/89



| BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within — nows after death. Page 6 may be retained by the hospital or attending physical DTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPURIANT: If tem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |
|--|--|---|--|
| P.O. BOX 13146, | leath certificate be executed within 2oun attending physician and completely filled in ntal Hygiene prior to bunial, cremation, or | y, or other traumatic event, the me | |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within — fours after deat TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fun before the four that the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | Is marked, or item 23 shows any inju | |
| DIVIS | TO THE HOSPITAL DR ATTER TO THE FUNERAL DIRECTOR De filed within 72 hours after | IMPURIANT: IT ITEM 28 | |

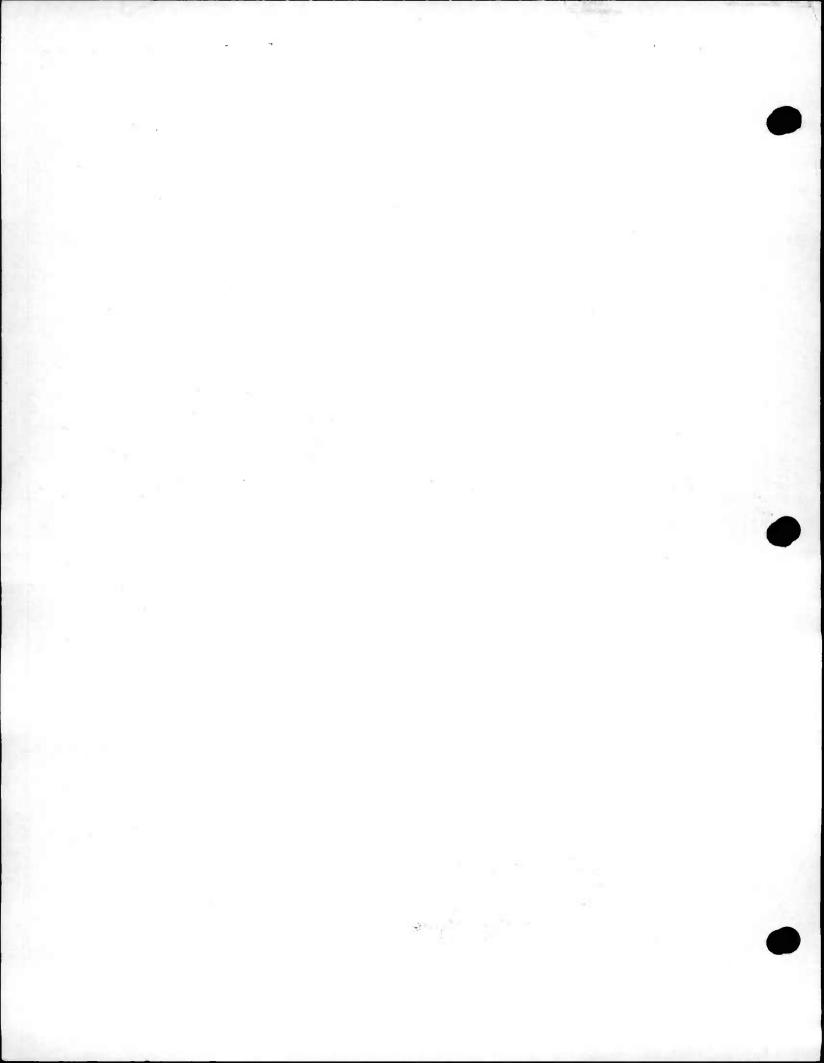
| | 1 - STATE REGISTRAR | STATE OF MARY | (LAND / DEPAR | TMENT OF H | EALTH AND ME | ENTAL HYGIEN | | | 34332 | | | | | | |
|-------------------|--|---|--|---|--------------------------------|---|--|-------------------------------------|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | at) | CERTIF | ICATE OF | | REG. NO |). | | | | | | | | |
| | Nellie Viola Ca | ngle | | | | MONTH OF | Ž3, 1 | 990 | 3. TIME OF DEATH 5:40 P | | | | | | |
| | 219-58-9148 | 1 □ M 2 🔀 F | 81 YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN | Month, Day, Year) 6/10/09 | | Country) | CACE (Stote or Foreign | | | | | | |
| 1 | 9a. FACILITY NAME (If not institution, give | | | | OR LOCATION OF DEATH | | 9c. COU | NTY OF DE | | | | | | | |
| DIRECTOR | Garrett Nemorial | | | 0ak1 | | | 1150/1100 | rrett | | | | | | | |
| | Maryland Pri | nty ince George's | | v, town or located | | | | | 10d. INSIDE CITY LIMITS? | | | | | | |
| *AL | 10s. STREET AND NUMBER | | | | ZIP CODE | | 10g. CIT | | IAT COUNTRY? | | | | | | |
| FUNERAL | 5306 Marlain Str | | | | 20748 | | | USA | AI GOOMING | | | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YE | R IN U.S. ARMED | 13. WAS DECF | ENDENT OF HISPANIC O | ORIGIN? (Specify Yes | or No- | 14. BACE - | - American Indien. | | | | | | |
| ВҰ | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR | S 2 AINO DATES | IT yes, spec | 2 NO Specify: | uerto Rican, etc.) | 01 1.0 | Bleck, | - American Indien, White, etc. | | | | | | |
| 垣 | 15, DECEDENT'S ED (Specify only highest grad | JUCATION (de completed) | 18a. DECEDENT'S I | USUAL OCCUPATION | N | 18b. KIND OF BUS | SINESS/INC | | 100 | | | | | | |
| 9 | Elementary/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT use | vork done during most e retired.) | t of working | C 2 C 2 C 2 C 2 C 2 C 2 C 2 C 2 C 2 C 2 | Althorn, | 031111 | | | | | | | |
| MP | • | U | Homema! | ker | | Hom | AQ. | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NAME (F | | | | | | | | | | |
| ш | Hilliam Liming | | | | | s Randall | | | | | | | | | |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street an | nd Number or Rural Route | | | Madel | | | | | | | |
| F | Nola Ludwig | | | | St., Temp1 | | | 20748 | | | | | | | |
| | 20s. METHOD DF DISPOSITION 1 Burlet 2 Cremation 3 Ref | | 10b. PLACE OF DISPOSI | ITION (Name of come | etery crematory or | | | City or Town | | | | | | | |
| | 4 Donation 5 Other (Specify) | moval from State | | | ts. Cemete | | | | | | | | | | |
| | THE MATLINE OF FUNERAL SERVICE L | .ICENSEE | Office octing | 22. NAME AND | D ADDRESS OF FACILITY | rv | | nam, | Maryland | | | | | | |
| J | to Illy | () . | - | Fleck | k Funeral | Home Inc | | | | | | | | | |
| | Mu. | July 1 | Nex | 7601 | Sandy Spr | ring Pd 1 | aurol | I. AD | 20707 | | | | | | |
| | 23. PART I. Enter the diseases, or shock, or heart fellure. | complications that cause b. List only one cause on | ed the death. Do no | at enter the mode | e of dying, such as | cardiec or respir | ratory srr | est, | Approximata | | | | | | |
| | IMMEDIATE CAUSE (Final | Pneumonia | accii mia. | | | | | | Interval Between Onset end Death | | | | | | |
| | disease or condition resulting in death) | | | | Oliser sine accu | | | | | | | | | | |
| | | | | | | | | | | | | | | | |
| Z | DUE TO (OR AS A CONSEQUENCE OF): Sepsis | | | | | | | | | | | | | | |
| F | Sequentially list conditions, if any, leading to immediate | U | A CONSEQUENCE OF): | ıt. | | | | | | | | | | | |
| CA | cause. Enter UNDERLYING CAUSE (Disease or Injury | е | | | | | | | | | | | | | |
| CERTIFICATION | that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | 4 | | | | | | | | | | | |
| FR | resulting in death) LAST | d | | | | | | | | | | | | | |
| CC | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | | | | |
| | Senile dementia | contributing to death | but not resulting in | the underlying o | cause given in Part | I. 24a, WAS AN A PERFORM | | | ERE AUTOPSY FINDINGS | | | | | | |
| MEDICA | Dentite demonstra | 1, Congestive | 3 Heart ra | llure | | 1 TES 2 | X | CC | MILABLE PRIOR TO OMPLETION OF CAUSE | | | | | | |
| ME | | | | | | | AL III | | F DEATH? | | | | | | |
| | | | | | | | | | YES 2 NO | | | | | | |
| Z | 25. WAS CASE REFERENCE TO MEDICAL | | | | | | | | | | | | | | |
| SIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: CTIMED: CTIMED: 26. PLACE OF DEATH (Check only one) | | | | | | | | | | | | | | |
| SICIAN | | | 1 Tes 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | | | | | | | | |
| HYSICIAN | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 ER/Out | tpatient 3 DOA 4 | OF 28c INJUR | | | 27. MANNER OF DEATH 28a. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCUPED | | | | | | | | |
| Y PHYSICIAN: | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | 1 Inpatient 2 ER/Out | tpatient 3 DOA 4 | OF 28c, INJURY WORK | RY AT 28d. | | JURY OCCI | VRED | | | | | | | |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 26a. DATE OF INJURY (Month, Day, Vear) 28e. PLACE OF INJURY | tpetient 3 DOA 4 26b. TIME (INJUR | OF 28c, INJUR WORK M 1 YES | RY AT 28d. K? S 2 NO | . DEŞCRIBE HOW IN. | | | | | | | | | |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 1 inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) | tpetient 3 DOA 4 26b. TIME (INJUR | OF 28c, INJUR WORK M 1 YES | RY AT | | | | » Number, | | | | | | |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined | 1 inpatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe | tpatient 3 DOA 4 26b. TIME: (INJURI | 6 Mursing Mome OF 28c, INJUR WORK 1 YES reet, factory, office | RY AT K? 28d. K? S 2 NO 28f. I | LOCATION (Street end City or Town, State) | nd Number o | or Rural Route | e Number, | | | | | | |
| BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1X) CERTIFYING PHYSI | 1 impatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe | tpatient 3 DOA 4 28b. TIME (INJUR IY — At home, farm, strescity) wiedge, death occurred | OF 28c, INJUR WORK M 1 YES eet, factory, office | RY AT K? 28d. K? 28f. l | LOCATION (Street en City or Town, State) | nd Number o | or Rural Route | | | | | | | |
| COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe | tpatient 3 DOA 4 28b. TIME (INJUR IY — At home, farm, strescity) wiedge, death occurred | OF 28c, INJUR WORK M 1 YES eet, factory, office | RY AT K? 28d. K? 28f. l | LOCATION (Street en City or Town, State) | nd Number o | or Rural Route | | | | | | | |
| E COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1X) CERTIFYING PHYSI | 1 impatient 2 ER/Out 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe SICIAN: To the best of my know ER: On the basie of examination | tpatient 3 DOA 4 28b. TIME (INJUR IY — At home, farm, stresciry) wiedge, death occurred on end/or investigation, | 6 Nursing Home OF 28c. INJUT WORK I VES eet, factory, office at the time, date and in my opinion, deati | RY AT K? 28d. K? 28f. l | LOCATION (Street end City or Town, State) e ceuse(e) end menne date end piece, end | nd Number of | or Rural Route d. ceuse(e) en | id menner ee stated. | | | | | | |
| O BE COMPLETED BY | EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be detarmined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | 28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY building, etc. (Spe BICIAN: To the best of my know ER: On the basie of examination | tpatient 3 DOA 4 26b. TIME (INJUR IY — At home, farm, streecify) wiedge, death occurred on end/or investigation, | 6 Nursing Home OF 28c. INJUR WORK 1 YES set, factory, office at the time, data and in my opinion, deati | RY AT 28d. K? 2 NO 28f. I | LOCATION (Street end City or Town, State) e cause(e) end menn- date end piece, end | nd Number of the state of the to the 29d. DATE: | or Rural Route d. ceuse(e) en | od menner ee stated. | | | | | | |

John T. Turski, III, D.O., P.O. Box 67, Friendsville, MD 21531

31. DATE FILED (Month, Day, Year)

10 12 24 79 090

32. REGISTRAR'S SIGNATURE



DIRECTOR

FUNERAL

ВУ

COMPLETED

BE

2

PHYSICIAN: MEDICAL CERTIFICATION

ВҰ

COMPLETED

BE

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| 13146, | | . | ALTI | MOR | щì | BALTIMORE, MARYLAND 21203-3146 | 3 | ND 2 | 120 | 3-31 | 46 | |
|--|--------------|----------|-----------|-----------|-------|--------------------------------|-----|------------|--------|---------|----------------|-------|
| executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician. | 74-4000 | s arrer | death. | rage b n | ay be | retained | ž. | ne hospita | or at | tending | physician. | |
| , and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit nermit | ly filled in | by th | e funeral | director, | Dade | 5 should | bed | letached 1 | or use | as the | burial-fransit | nermi |

DIVISION OF VITAL RECORDS, P.O. BOX

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-rours after death. Page 6 may be retained by the hospital or attending physician | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tran | within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|--|--|
| HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after | FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the | within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or remov | ANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical |

REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY 3. TIME OF OEATH Bernadine COLEMAN DECEMBER 06 1990 10.02 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign Country) IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 1 🗌 M 2 🔲 F YRS. 222 20 5455 3-2-37 DE 9a. FACILITY NAME (if not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? MD Calvert Dunkirk 1 YES 2 NO 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 11624 Rivershore Drive 20754 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 222NO 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yea or No-if yes, specify Cuban, Mexican, Puerto Ricen, etc.) RACE — American Indien, Black, White, etc. FORCES? 1 YES 2X 1 Never Married 2 Married 1 YES ZXNO Specify: Specify: 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4 or 5+) 12 Recording Secretary Regional Gov't. 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Frank Golebiewski Helen. Grodziski 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) James J. Coleman same as 10 above 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20a. METHOD OF DISPOSITION 20c. LOCATION — City or Town, State 1
☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 8 Other (Specify) Southern Memorial Gardens Dunkirk (Calvert) MD 21. SIGNATURE OF FUNERAL SERVICE LICENSE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD 20736 23. PART V. Enter the disessee, or complications that caused the death. Do not enter the mode of dying, such se cerdiac or respiratory erreet, Approximets shock, or heart fallure. Liet only one ceuse on each line. Interval Between IMMEDIATE CAUSE (Finei **Onset end Desth** pneumonitis diesse or condition Radiotion recuiting in deeth) DUE TO (OR AS A CONSEQUENCE OF): -ung cancer -Sequentially list conditione, DUE TO (OR AS A CONSEQUENCE OF): If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disesse or injury OUE TO (OR AS A CONSEQUENCE OF): thet initieted events resulting In desth) LAST PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINGINGS AVAILABLE PRIDR TO COMPLETION DF CAUSE 1 🗌 YES 2 🙀 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 29. PLACE OF OEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO nt 2 - ER/Outpetient 3 - DOA 4 - Nursing Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 26d. DESCRIBE HOW INJURY OCCURED 1 Naturel 5 Pending 1 TYES 2 NO Investigation 2 Accident 3 Suicide 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29a. CERTIFIER
(Check only one)

CERTIFING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as ateted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNEO (Month, Day, Year) MO D35820 12 90 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eckberg MO Fox Lane #110 Bowie MO Gallant 14700 22. REGISTBAR'S SIGNATURE funda Davidson- Manda Davidson-Manda Davidson-31. DATE FILED (Month, Day, Year) 2 1990

BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 1 | FOR STATE REGIST |
|---|------------------------|
| ì | 1. DECEDENT |
| ŀ | 4. SOCIAL SEC |
| ı | 147 |
| Ī | 9a. FACILITY N |
| - | PRINCE |
| | Md |
| | 100. STREET A |
| - | 11. MARITAL S |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | | C | ERTIFIC | ATE OF | DEATH | F | EG. NO. | | |
|--|------------------------|---|--|-----------------------------------|------------------|---|-----------------------------------|---------------------------------|-------------------|--|
| 1. DECEDENT'S NAME (First, M | fiddie, Last) | | | | | | 2. DATE OF | DEATH | | 3. TIME OF DEATH |
| PHIL | OMENA | | CICCO | ONE | | | MONTH 11/27 | /90 DAY | YEAR | 7.30PM M |
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In yrs. le | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF E | HTRE | 6. BIRT | HPLACE (State or Foreign |
| 147 14 4513 | 3 | 1 - M 2XXF | 71 | YRS. | ONTHS DAYS | HOURS MIN. | (Month, Da | y. Year) 5-1919 | Coun | try) |
| 9a. FACILITY NAME (If not inati | | | | | L CITY TOWN | OR LOCATION OF DE | | _ | OUNTY OF | IJ |
| | | | | 1 | | | -AID | 96. 0 | OUNIT OF | DEATH |
| PRINCE GEORG | ES HOS | SPITAL C | ENTER | | CHEVE | RLY | | PRI | NCE G | EORGE |
| | 0b. COUNTY | | | 10c. CITY, 1 | OWN OR LOC | ATION | | | | 10d. INSIDE CITY |
| Md | Pri | nce Geor | COC | 90 | abrool | _ | | | | LIMITS? |
| 10e, STREET AND NUMBER | | 100 0001 | gcs | 56 | | Of. ZIP CODE | | 100 | OUTUSEN OF | 1 YES 2 □ NO WHAT COUNTRY? |
| 9517 Dubar | Asr | 22110 | | | Ι, | | | log. | | WHAT COUNTRY? |
| | | | | | | 20706 | | | USA | |
| 11. MARITAL STATUS 1 Never Married 2XXM. | erried | 12. WAS DECEDENT FORCES? 1 | YES 2 | RMED NO | 13. WAS DE | CENDENT OF HISPAN pecify Cuban, Mexica | IIC ORIGIN? (S n, Puarto Rica: | pecify Yea or No- 1, etc.) | - 14. RAC Blac | CE — American Indian, ck, White, atc. |
| 3 Widowed 4 Divorce | | IF YES, GIVE W | AR OR DATES | | | S ZNO Specify | | | Spe | clty: |
| 45 DECED | ENT'S EDUCA | TION | 1000 | | | | | | 1 | White |
| (Specify only h | ighest grade co | impleted) | (| ECEDENT'S US Give kind of work | k done during n | ION lost of working | 18b. KIN | ID OF BUSINESS. | INDUSTRY | |
| Elementary/Secondary (0-12 | 2) | College (1-4 or 5+ |) " | e. Do NOT use n | , | | | | | |
| | | 00 | | Housew | rife | | Ow | n Home | -17 | |
| 17. FATHER'S NAME (First, Midd | | | | | | 16. MOTHER'S NA | ME (First, Middle | le, Malden Surnam | (e) | |
| Angelo | Melil | ΓŢΟ | | | | Ar | menia | Del Ga | rcio | |
| 19a. INFORMANT'S NAME (Type | e/Print) | | 1 | 96. MAILING AD | DRESS (Street | and Number or Rural I | Poute Number, (| City or Town, State | Zip Code) | - |
| Pasquale C | iccone | 2 | g | 517 Di | barry | Ave., Se | abrook | MD 20 | 706 | |
| 20a. METHOO OF DISPOSITION | N | | 20b. PLACE | OF DISPOSITI | | emetery, cremetory or | -DIOOK | 20c. LOCATION | | own. State |
| 1-Buriel 2 Cremetion 4 Donation 5 Other (S | 3 - Removi | al from Stata | other p | Hace) | | Cemetery | | | | -, |
| 21. SIGNATURE OF FUNERAL | | | I | surrec | ~ | AND ADDRESS OF FA | OILITY | Clint | on, M | <u>D</u> |
| | // | | | | Rendo | n/Hale La | anham i | Funeral | Ноте | . P.A. |
| La Ca | man | 1 Xera | m | | | Annapoli: | | | | 20706 |
| 23. PART I. Entar the diseases, or complications that caused the death. Do not entar the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart feliure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| DART II. Other elgolficent | conditions | 000000000000000000000000000000000000000 | de est. bus a ca | 44 | | | | | | |
| PART II. Other algnificant | | continuoting to | Description of | resulting in | ina underlyi | ng ceuse given in | Part I. 24s | PERFORMED? | SY 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO |
| ONDURAL | | monne | ns | 7 | | | 16 | YES 2 - NO | | COMPLETION OF CAUSE OF DEATH? |
| MABERL | 80 8VG | | | | | | | | | 1 - YES 2 - NO |
| con. | ur. | MISSON | Ö | DOST | cm | D/ST | | | | |
| 25. WAS CASE REFERRED TO I | | | | 1 | | PLACE OF DEATH (Ch | eck only one) | | | |
| EXAMINER? | | HOSPITAL: | ER/Outpatient | | THER: | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE OF | INJURY | 28b. TIME C | | me 5 🗆 Rasidence | | BE HOW INJURY | OCCUPED | |
| 1 Natural 5 Pe | | (Month, De | | INJUR | Y | ORK? | Lou. DEQUAI | SE NOW INJUST | CCCOMED | |
| - L Producerit | restigation | 200 BLACE CO | AN HARRY ATT | | | YES 2 NO | | | | |
| | uld not be termined | building, | INJURY — At h utc. (Specify) | ome, farm, stre | et, factory, off | ca | City or To | N (Street and Nun wn, State) | nber or Rurai | Route Number, |
| | | | | | | | | | | |
| 29e. CERTIFIER 1 CERTIF | YING PHYSICIA | AN: To the best of | my knowledge, d | leath occurred a | at the time, de | e and place, and due | to the cause(s |) and manner as | stated. | |
| | | | | | | | | | | (a) and manner as stated. |
| 29b. SIGNATURE AND TITLE O | | | | | | | | | | |
| W 0 | A. S. | A Men | | | | 29c. LICENSE NUN | NER | 29d, 1 | DATE SIGNE | D (Month, Day, Year) |
| 20 11115 1111 1111 | | V1 100 | 1 | BLELI | Mr | mo , | 1619 | 7 | W- | 27-99 |
| 30. NAME AND ADDRESS OF P | ERSON WHO | COMPLETED CAUS | E OF DEATH (IT | EM 27) (Type, Pri | int) | HBMES | C., | Lav | In | 11.4.4 |
| 60 | | | | _ | | | | A B12 E | - 8-3 - | WWW. |
| 13 % VA | HARM | | m p | V) , V | A CA | WW. | M | 201 | 01. | my |
| 31. DATE FILED (Month, Day, Vo. | | | THE POST OF THE PO | ٧) ۲ | A CA | W. | M | 201 | 01. | ong - |

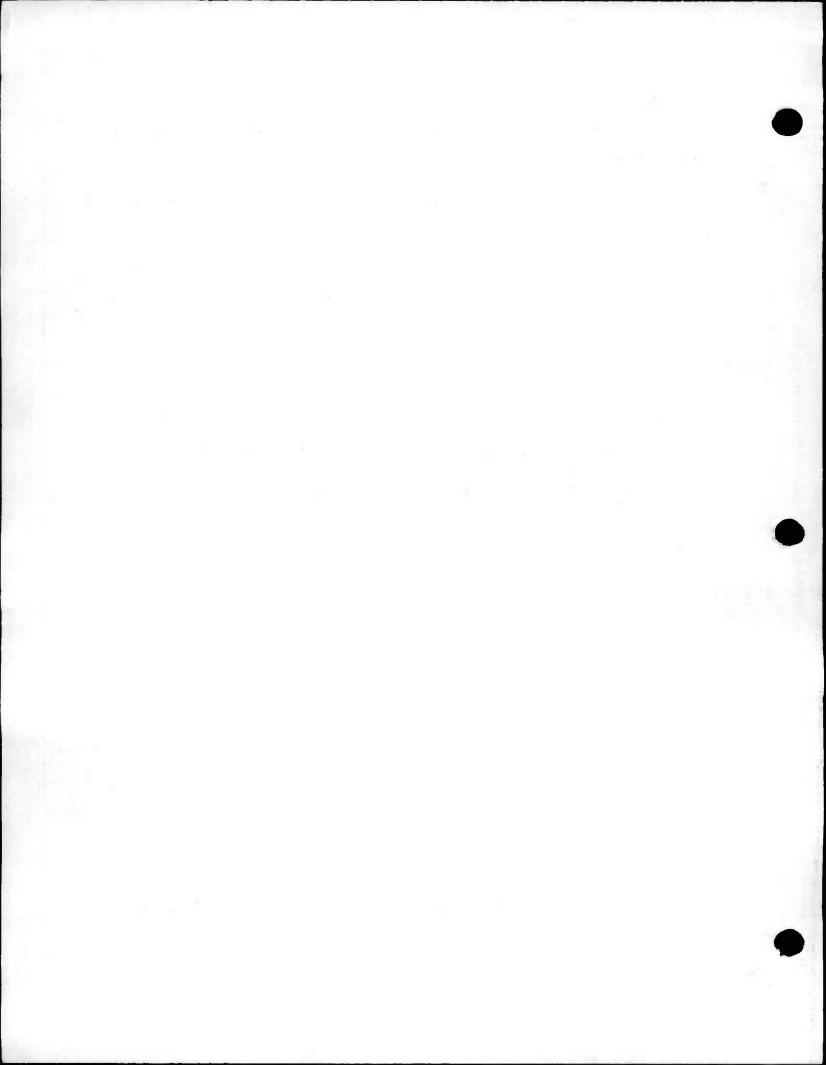
| 1203-3146 |
|-----------------------------------|
| D 21203-3146 |
| BALTIMORE, MARYLAND 21203-3146 |
| MORE, MARYLA |
| BALTIN |
| BOX 13146, |
| OF VITAL RECORDS, P.O. BOX 13146, |
| F VITAL REC |
| DIVISION OF |
| |

| | | | | | | | | | | | 90 | 3433! |
|--------------------|--|--|---------------------------------|--------------|-----------------------------------|--------------|------------|------------|---------------------------------|---------------|--|---|
| | 1 - FOR STATE REGISTRAR | STATE OF MARYLAND |) / DEPAI | | | | | MENTA | L HYGIEN REG. NO. | _ | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | 0 | | | | | | 2. DATE | E OF OEATH | v | YEAR 3 | . TIME OF OEATH |
| | EARL SION | EY COURT | NEV | | | | | // | 2 | 5 | 90 | 3:27 7 |
| | 4. SOCIAL SECURITY NUMBER | 8. SEX 6. AGE (In yrs. | - | IF UNDE | R 1 YEAR | IF UNDER | MIN. | | OF BIRTN th, Day, Year) | | 8. BIRTNPL Country) | ACE (State or Foreign |
| | 215-34-7238 | 1 0 4 2 0 F 7 | YRS. | MONTHS | DAYS | HOUNE | mire. | | 22-191 | 4 | C | ALIF |
| - | 9e. FACILITY NAME (If not institution, give st | | | 9b. CIT | Y, TOWN C | R LOCATI | ON OF D | EATN | | 9c. COUN | TY OF DEA | тн |
| ē. | CHARLOTTE HA | 1 VETERNS H | OME | 6 | HAL | John | HE. | HAII | | 57 | M | 1215 |
| DIRECTOR | 10a. STATE 10b. COUNTY | | 10c. Cl | TY, TOWN | OR LOCAT | ION | | | | | 1 | 0d. INSIDE CITY LIMITS? |
| | | e George's | C | heve | erly | | | | | | 1 | X YES 2 NO |
| IAL | 10e. STREET AND NUMBER | | | | 101 | . ZIP COD | | | | | | AT COUNTRY? |
| Æ | 6202 Inwood Stree | et | | | | 2078 | 35 | | | υ.: | S.A. | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Nidowed 4 Divorced | 12. WAS DECEDENT EVEN IN U.S. FORCES? 1 TYES 2 IF YES, GIVE WAR OR DATES | □ NO | 13 | . WAS DEC If yes, sp 1 TYES | ecify Cube | th, Mexica | in, Puerto | N? (Specify Yea Rican, etc.) | or No— | Black, | American Indian, White, etc. |
| | 15. DECEDENT'S EDUC (Specify only highest grade | ATION 18e. | DECEDENT'S | S USUAL (| OCCUPATIO | ON | | 16 | b. KIND OF BU | SINESS/INDU | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of Ilfe. Do NOT o | use retired. |) auring mo | st of work | ng | | | | | |
| MP. | 12th | C | lerk | | , | | | P | .G. Co | . Fir | e He | adquarters |
| Ö | 17. FATNER'S NAME (First, Middle, Last) | | | | | 18. MOT | NER'S NA | ME (First, | Middle, Malden | Surneme) | | |
| ш | John Courtney | | | | | Ain | nee | | () | unava | ilable | e) |
| TO B | 194. INFORMANT'S NAME (NOTE PRO) | | 19b. MAILIN | G AODRES | SS (Street a | nd Numbe | r or Rural | Route Nun | nber, City or Tow | n, State, Zip | Code) | - |
| F | Catherine/Courtne | ≱ y _ | 6202 l | nwo | od S | tree | t, C | heve | erly, M | Maryla | and | 20785 |
| | 30. METHOD OF DISPOSITION X Burisl 2 Germation 3 Department | oval from 10to Z dos | CE OF OISPO | SITION (M | Vame of cen | netery, crer | metory or | No. of | 20c. LO | CATION — C | ity or Town | , State |
| | The section of the se | The property | yland | Sta | te V | eter | ans | Cem | . Che | eltenh | nam, | Maryland |
| | 21. BIGHATURE OF FUNEBAL SERVICE FOR | 1 Sween | ~ | F 4 7 | RANG 739 E | CIS Balt. | GAS Av | CH'S | S SON: Hyatts | S FUI | NERA Md. | AL HOME 20781 |
| | shock, or heart failtire. List only one cause on each line. | | | | | | | | | | Approximata Interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| F | requiting in death) LAST | | | | | | | | | | | |
| | PART II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other aignificant conditions | i contributing to deeth but h | ot resulting | in the u | inderiyin | g cause | given in | Part I. | 24a. WAS AN PERFOR | RMED? | | PERE AUTOPSY FINDINGS MAILABLE PRIOR TO |
| ă | | | | | | | | | 1 🗆 YES | X NO | | OMPLETION OF CAUSE OF DEATH? |
| X | | | | | | | | _ | | | 1 | YES 2 NO |
| Ä | | | | | | | | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHE | | ACE OF D | DEATH (Ch | eck only o | nne) | | | |
| ΙΥS | 1 YES 2 NO | 1 Inpatient 2 ER/Outpatien | - | 1 . | 7 | | esidence | | er (Specify) | | | |
| | 1 Natural 5 Pending | 26e. DATE OF INJURY (Month, Day, Year) | 28b. Til | JURY M | | PIC? | 7 | 28d, DE | SCRIBE HOW I | NJURY OCC | URED | |
| TED BY | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 26e. PLACE OF INJURY — A building, atc. (Specify) | t home, farm, | | | YES 2 | | 281. L.O. | CATION (Street or Town, State) | end Number | or Rural Ro | ite Number, |
| COMPLETED | 1-11-11-11-1 | CIAN: To the best of my knowledge R: On the basis of examination and | | | | | | | | | | and menner as stated. |
| Ü | 29b. SIGNATURE AND TITLE OF CENTURES | 4/ 1 | | 7 | | 29c. LIC | ENSE NU | MBER | | 29d. DATE | SIGNED /A | fonth, Day, Year) |
| TO B | 30, NAME AND ADDRESS OF PERSON WHO | act 3 | \swarrow | | | D 3 | 75 | -22 | 2 | | 1-25- | |

D39522 ▶ 11-25-90

Charlotte Hall Veterans Home, Charlotte Hall, Md. 32. REGISTRAR'S SIGNATURE Lavidson-Randelle

NOV 30 90

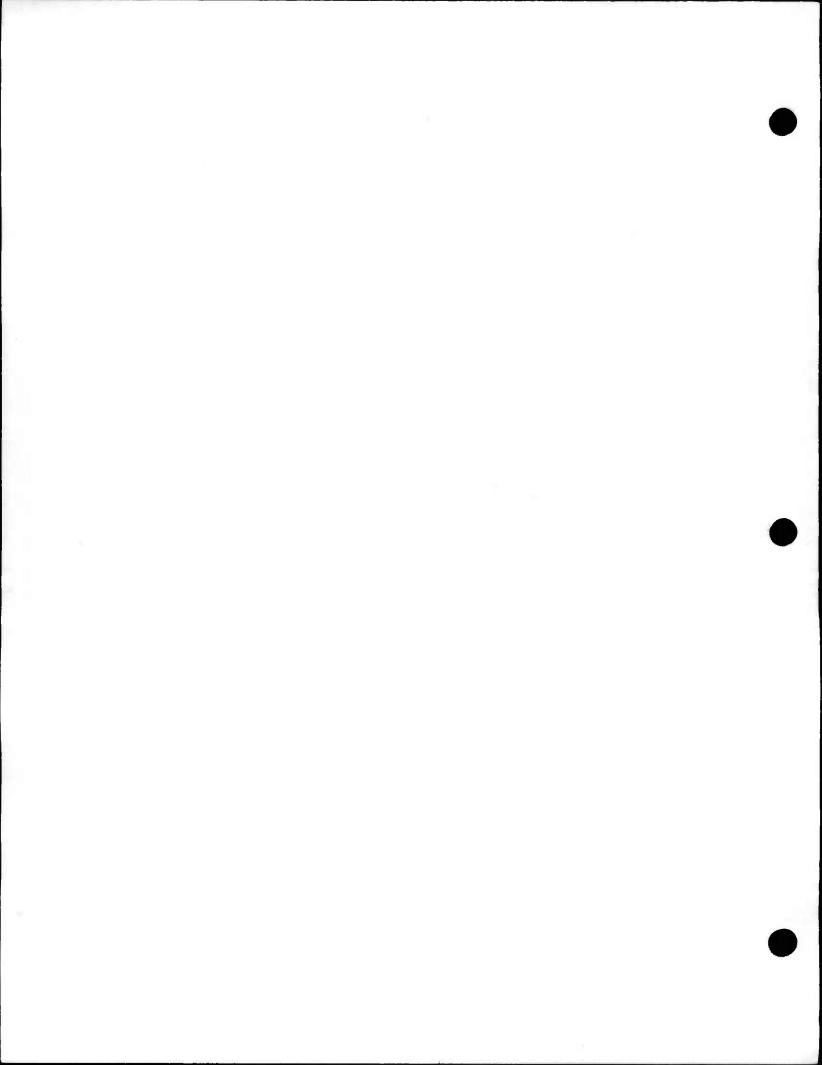


TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cartificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1. The filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial. cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

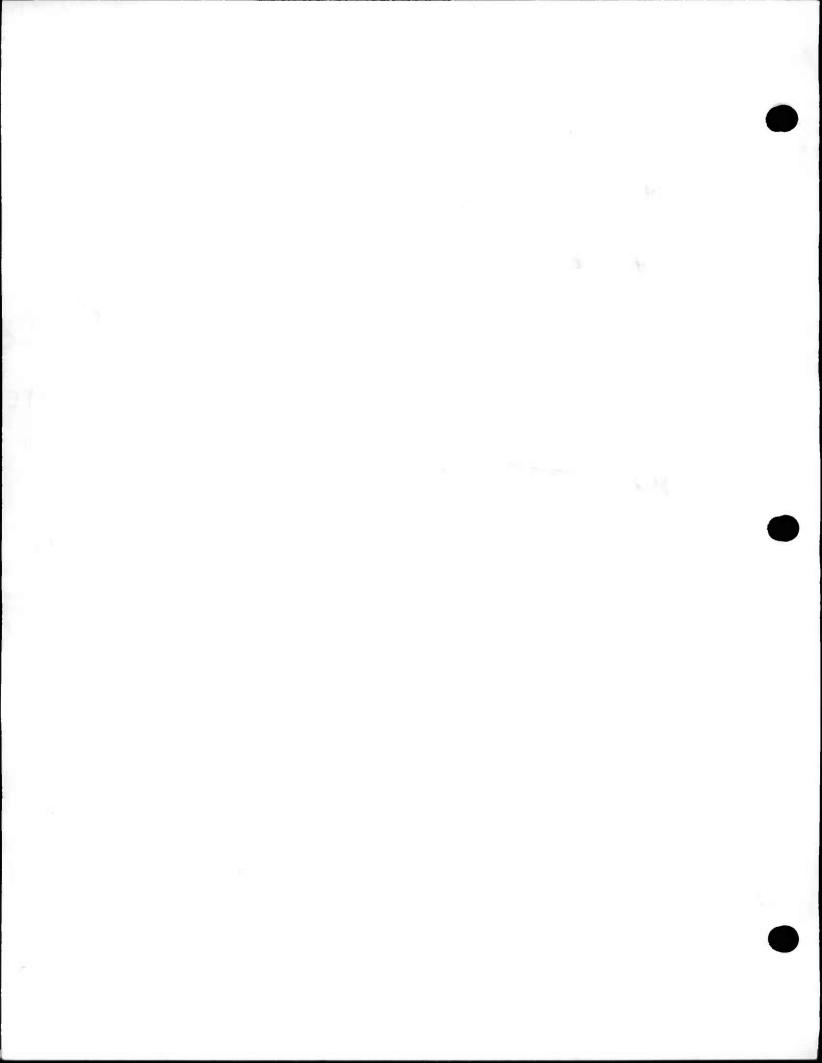
| 1 | FOR STATE REGISTRAR | STATE OF MARYL | | TMENT OF CATE OF | | | NTAL HYGIENE REG. NO. | | | |
|-----------------|--|--|---|-----------------------------|-------------------------|--------------|-------------------------------------|---|-----------------------|---------------------------------|
| | 1. DECEOENT'S NAME (First, Middle, Last | | | | | 1.0 | DATE OF DEATH | , , | YEAR . | ME OF DEATH |
| | Lillian | M. Cass | Well | | | N | Jovember | 24,19 | 90 4 | :16 am |
| | 4. SOCIAL SECURITY NUMBER | 200 | In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | HOURS N | HRS. 7. I | DATE OF BIRTH (Month, Day, Year) | | Country) | E (State or Foreign |
| | 577-18-7506 | 1 🗆 M X(X,F | 69 YRS. | | | - | 4-17-2 | | Y OF OEATH | Md. |
| œ | 9a. FACILITY NAME (If not institution, give | The state of the s | 1.1 | 9b. CITY, TOWN | OR LOCATION | OF DEATH | | ~ | | - 10.4 |
| ᅙ | Southern Mary | land Hospi | tal | <u>Ui</u> | NAOD | - | | 47170 | 10 64 | corges |
| DIRECTOR | 10a. STATE 10b. COUN | | 10c. CITY | , TOWN OR LOC | | | | | 10d. | INSIDE CITY LIMITS? |
| ੂ | | ·.G. | | Clin | | | | | | YES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | - D1 | | " | DI. ZIP CODE | 735 | | 10g. CITIZE | EN OF WHAT | COUNTRY? |
| | 9102 Natahal | 12. WAS DECEOENT EVER II | VIIS ARMED | 13 WAS D | | | PRIGIN? (Specify Yes | or No.— 1 | USA 14. RACE — AI | merican Indian, |
| | 1 Never Married 2 Married | FORCES? 1 YES | 2X NO | If yes, s | | Mexican, Po | verto Rican, etc.) | | Black, White Specify: | ta, atc. |
| ਨੂੰ | 3 Widowed 4 Olvorced | W 120, GIVE MIN ON D | | | 3.23 | .,,. | | | W | hite |
| | 15. DECEDENT'S EC (Specify only highest gra | OUCATION de completed) | 16a. OECEDENT'S (Give kind of w | vork done during r | TION nost of working | | 16b. KIND OF BUS | INESS/INDU | STRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT us | • retired.) nemake | r | | Own | Home | e | |
| COMPLETED | 1.2 | 0 | 1101 | - ICMONE | | S NAME / | First, Middle, Maiden | | | |
| | James Morris | | | | | CITY NO. | Burcher | our amoy | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | 19b, MAILING | AOORESS (Stree | | | Number, City or Town | n, State, Zip (| Code) | |
| 임 | Edwin G. Cas | swell | Sa | ame as | 10a-3 | 10f. | | | | |
| | 20a_METHOD OF DISPOSITION 1 Burlal 2 Cremation 3 Re | amoval from State | b. PLACE OF DISPOS | SITION (Name of o | emetery, cremate | ory or | | | Ity or Town, S | |
| | 4 Donation 5 Other (Specify) | | Resurre | ection | Cemet | tery | C1 wLee Fu | into | n,Md. | o Tro |
| | 21. SIGNATURE OF FUNCAL SERVICE | LICENSEE | 1 | | | | мьее ги xander | | | |
| 5 | Marine | ~ 11/1 | | Cli | nton, N | 1d. | 20735 | | 2 | |
| | 23. PART I. Enter the diseases, o | r complications that cause a. Liet only one cause on a | | not enter the n | node of dying | g, such a | s cardiec or respi | retory erre | st, | Approximete intervel Between |
| | IMMEDIATE CAUSE (Finel | | | | | | | | | Onset end Deeth |
| | disease or condition resulting in death) | · CARO | to Pulhe | NACY | FA | -144 | N | | | 8 when |
| | DUE TO (OR AS A CONSEQUENCE OF): DEWAL FAILURE / CHF | | | | | | | | | 8 whs |
| o No | MMEDIATE CAUSE (Finel disease or condition resulting in death) CAROLO PYCHONARY FALLUME | | | | | | | | | |
| SAT | If any, leading to immediate cause, Enter UNDERLYING CANCER ABOOMEN (LIPS SARCOMA CANCER Disease or injury | | | | | | | | 1/ | 5.5 |
| Ě | thet initiated evente | DUE TO (OR AS | A CONSEQUENCE O | SEQUENCE OF): | | | | | | |
| | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERIVING CAUSE (Disease or injury that initiated evente resulting in death) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | ——- İ | |
| | | _ | , | | | | | | | |
| ICAL | - Mys | ich | PE | | | | | PERFORMED? AVAILABLE COMPLETI OF DEATH | | |
| | Sec. | · | | | | | | | | YES 2 NO |
| N | | | | | | | | | | |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | PLACE OF DEA | ATH (Check | only one) | | | |
| ISA | 1 TYES 2 NO 27. MANNER OF CEATH | 1 ☑ Inpatiant 2 ☐ ER/Out | tpatiant 3 DOA | | ome 5 Resi | - 7 | Other (Specify) | IN II IBY OCC | TIREO | |
| | 1 Natural 5 Pending | (Month, Day, Year) | | JURY | WORK? | 1.0 | Bu. DESCRIBE (101) | MUUNI OCC | ONLO | |
| BY | 2 Accident Investigation 3 Suicide 8 Could not | 28a. PLACE OF INJUR | | | | - | Bf. LOCATION (Street | and Number | or Rural Route | Number, |
| COMPLETED | 4 Homicide S Could not a | | ecify) | | | | City or Town, State | , | | |
| Ë | 29a. CERTIFIER 1 CERTIFYING PH | IYSICIAN: To the beat of my kno | wledge, death occur | red at the lime, d | ate and place, a | and due to | the cause(s) and ma | nner as state | ed. | |
| N N | | INER: On the basia of axaminati | on and/or investigation | on, In my opinio | , death occurs | d at the tim | ne, data and place, a | nd due to the | e cause(a) and | manner as stated. |
| EC | 29h. SIGNATURE AND TITLE OF CERTI | FIER | | 1 | | ISE NUMBE | | | E SIGNED (Mor | |
| m | 1 | MB (F.G | . LEON |) 140 | D' | 353 | 45 | • | 11-25 | -90 |
| 5 | 30. NAME AND ADDRESS OF PERSON | | EATH (ITEM 27) (Type | Print) | Wa | (دکه، | 45 12, My |) | 2060 | 2_ |
| | NUV 2 9 90 | 32. REGISTRAR'S SIG | | | | | | | | |
| | The Same of the Same | | V*775 | | | | | | | |



1 - FOR STATE REGISTRAR

| | | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE | OF DEATH | NA. | YEAR | 3. TIME OF D | EATH | |
|---|---------------|--|--|-------------------------------------|------------------------------|---|------------|------------------------------------|-------------|----------------|--------------|-------------------|------------------------------|--------------------|-----|
| | | THOMAS | JA1 | nes (| COL | .6 | | | 11 | 2 | | 10 | 6 | 19 | M |
| | | 4. SOCIAL SECURITY NUMBER | | 8. AGE (In yrs. la | st birthday) | IF UNDER | DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. OATE (| Day, Year) | | 6. BIRTH | PLACE (State of | r Foreign | |
| | 1 | 577 07 2520A | 1 XM 2 F | 79 | YRS. | MONINS | DAYS | HOURS MIN. | 2 - | 19- | | S.C | | | |
| | | 9e. FACILITY NAME (If not institution, give st | reet and number) | | | 40 | | R LOCATION OF | DEATH | | 9c. COUN | | | | |
| | e B | | treet | | | Ch | ev | erly | | | Trin | ce! | Yeon | 98 | _ |
| 8 | ECTOR | RESIDENCE OF DECEDENT 10e, STATE 10b, COUNTY | | | 10c. CIT | Y, TOWN O | R LOCAT | TION | | | | T | 10d. INSIDE (| CITY | _ |
| Page | DIE I | MD Princ | · Hen | 4.2 | CI | new | erl | 4 | | | | | 1 YES 2 | □ NO | |
| ermit. | | 10e. STREET AND NUMBER | 0. | _ | | | 101 | . ZIP CODE | | | 10g. CITIZ | EN OF V | VHAT COUNTR | Υ? | |
| physician. burlal-transit permit. Pages | FUNERAL | 6004 Reed | 1 tra | es | | | | 20785 | | | Uni | ted | Stat | es | |
| physician. burial-tran | 5 | 11. MARITAL STATUS | 12. WAS DECEDEN | T EVER IN U.S. A | | | | ENDENT OF HISP ecity Cuben, Mex | | | e or No- | 14. RACE Black | - American c, White, etc. | Indien, | |
| | BY F | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | IF YES, GIVE W | | | 1 | ☐ YES | 2 NO Spe | cify: | | | Spec | rack | | |
| r attending use as the | | 15. DECEOENT'S EDUC | CATION | 16e. D | ECEDENT'S | USUAL O | CCUPATIO | ON | 16b | KIND OF BU | SINESS/IND | | 7 - 10 - | | |
| | | (Specify only highest grade Elementary/Secondary (0-12) | completed) College (1-4 or 5 + | - in | Give kind of le. Do NOT u | work done o | during mo | ost of working | | | | | | | |
| hospital or ached for | 급 | 8th grade | College (1-4 of 5) | ' | Eng | inee | r | | | Publi | c Sc | hoc | ls | | |
| the hospit detached once. | COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTHER'S | | | Surname) | | | | |
| ज व द | 1 1 | Samuel J. Cole | ,Sr. | | | | | <u> </u> | e Le | | | | | | |
| retained to 5 should notified | 10 B | 19e. INFORMANT'S NAME (Type/Print) | | 1 | | | | and Number or Ru | | | | | | | |
| | F | Ruby S. Cole | | | | | | Stree | | | erly | _ | | _ | _ |
| leath. Page 6 may be funeral director, page xaminer must be | | 20 METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Rem | oval from State | other | (acale | | | al Par | | 20c. L | CATION — | | r, Md. | | |
| Page 6 | | 4 Donation 5 Other (Specify) | Ellsii — | _ Hall | liOlly | | | ND ADDRESS OF | | | Danc | OVE | I , Ma | | _ |
| death. Pag funeral di examiner | | Val T | 17011 | 1 | TI | S | tew | art Fu | nera | l Hon | ne | | | | |
| | 1.0 | JAW 1.X | uevo. | an | 10 | | | Benni | | | | | 1.0 | 1 | _ |
| rs aff | | 23. FART I. Entar tha diseases, or ahock, or heart fallure. | complications tha List only one cau | it causad tha d use on sach iii | daath. Do na. | not antar | tha mo | oda of dying, s | uch as car | diac or rea | piratory arr | eat, | interv | ximata ai Betwe | |
| filled in or or ne me | 1 | IMMEDIATE CAUSE (Final | Δ. | , | | | | | , | | | | 1 | and Da | |
| ~== | | displace or condition ———————————————————————————————————— | a. MYOC | aRdia | ECHENCE | N F | AR | CIJON | | | | | 141 | 004 | |
| axecuted within and completely oburial, crema matic event, | _ | | a. Myoc. b. ARTER | an CCI EL | 2422 | / AG | NA. | VASCUL | AR A | ICEA | 5 | | 4 | ear | -5 |
| be executivities and confident to buring traumatic | CERTIFICATION | Sequantially list conditions, if any, leading to immediate | b. DUE TO | (OR AS A CONS | EOUENCE | OF): | | ,,,,, | 7. 4 | | | | | | _ |
| trau | SAT | cause. Entar UNDERLYING | c | | | | | | | | | | | | |
| certificate ding physic hygiene pri | Ē | CAUSE (Diseasa or injury that initiated evants | DUE TO | OR AS A CONS | EOUENCE | OF): | | | | | | | i | | |
| . = = = 0 | EH | reaulting in death) LAST | d | | | | | | | | | _ | | | - |
| that the death the by the attent the and Mental the any Inlury. | | PART ii. Other algnificant conditio | na contributing to | daath but no | t reaulting | in tha u | nderlyli | ng cause giver | in Part i. | | N AUTOPSY | 24 | b. WERE AUTO | | IGS |
| that the ed by the th and Mand Mand Mand Mand Mand Mand Mand | EDICAL | | | | | | | | | 1 TYES | | 1 | COMPLETION DF DEATH? | | E |
| sign sign | G | | | | | | | | | _ | | | 1 TYES | 2 NO | |
| T = = = = | | | | | | | | | | | | | | | |
| OF VITAL F PHYSICIAN: The law this certificate has b with the State Dept. | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ОТНЕ | | PLACE OF DEATH | (Check only | nne) | | | | | |
| VITAL SIAN: The strifficate h he State C | SIC | 1 X YES 2 NO | 1 Inpatient 2 | ☐ ER/Outpatient | 3 🗆 DOA | | | ome 5 Reelder | | | _ | | | | |
| OF VITA PHYSICIAN: Th this certificate with the State | E | 27. MANNER OF DEATH | 28e. DATE O (Month, | Day, Year) | 28b. T | IME OF | W | NJURY AT VORK? | 2307.00 | SCRIBE HOV | V INJURY OC | CURED | | | |
| | B | 1 Natural 5 Pending 2 Accident Investigation | | NIA | | М | | YES 2 NO | | 04710N (04 | | O | I Floute Number | | _ |
| | | 3 Suicide 6 Could not be | | OF INJURY — At J, etc. (Specify) | home, farm | n, street, fa | ctory, off | lice | | y or Town, Sta | | er or munii | node Namber | • | |
| DIVISION ATTERMENTS DIRECTOR HOURS after 18 Mary 28 | 4 I F | THE STATE OF THE S | | | | | | | | _ | 77 | y.11 | | | |
| DIV TAL DR / TAL DIRECT TO HOURS TO HOURS | 틸립 | (Check only | SICIAN: To the beat of | | | | | | | | | | (e) and manny | r ee state | d |
| HOSPITAL FUNERAL within 72 | | MEDICAL EXAMI | | examination end | or investig | mon, in my | opinion, | /- | | te end piece, | | | | | _ |
| THE HOSPI THE FUNER filed within | BE | 29b. SIGNATURE AND TITLE OF CERTIFI | ER 1 | BEDL | HYM | 1841 | cas | 29¢. LICENSE | |)_ | | | ED (Month, Day, | | |
| B-54 | 10 | 30, NAME AND ADDRESS OF PERSON W | WA COMBI ETED CA | BSE OF DEATH | KUM 27 C | 7/4 € | IR. | -0/ | 97. | | 1 , ,, | - 2 | 3-9 | U | _ |
| (41) | - | | URE M | & US | 2 / |) 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ih | Dol | 140 | ×++ | uslle | m | 1207 | 81 | |
| 0 | 1 | | | ART'S SIGNATUR | E | UTCH | Q K3 E | 1914 | . (4: | 7-7-3 | -11/1 | , ,,, | | | |
| | | 31 DATE FILED (Mort) (Day, Year) | 0 | | | | | | | | | | | | |

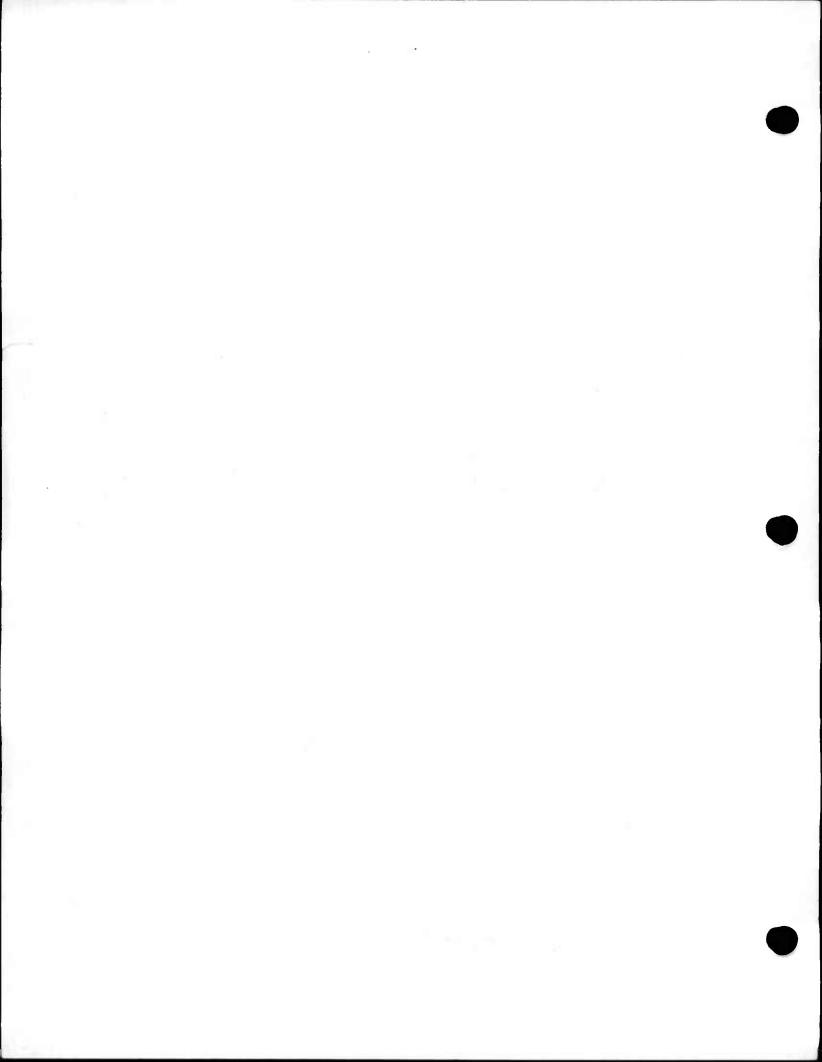
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



| 1 | FOR 1 - STATE REGISTRAR | STATE OF N | IARYLAND / DEPAF Certif | TMENT OF H | | MENTAL HYGII | | 90 34338 |
|------------------|--|--------------------|--------------------------------|-----------------------------|---------------------|------------------------------|--------------------------|--|
| į. | 1. OECEDENT'S NAME (First, Middle, Last) | | | | Ì | 2. DATE OF DEATH | DAY | 3. TIME OF DEATH |
| ľ | Sarah Collison | | | | | 12-02-9 | 90 | M |
| | | 5. SEX | 6. AGE (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | 8. BIRTHPLACE (State or Foreign |
| H | 214-38-5920 | 1 □ M 2 😾 F | 100 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year 10-13-9 | 0 | Mayo, MD |
| 1 | 9e. FACILITY NAME (If not institution, give stre | et and number) | 100 | 9b. CITY, TOWN O | R LOCATION OF DE | | | JNTY OF DEATH |
| œ | The second secon | | | | | | Ann | e Arundel |
| 2 | 30 Collison Ros | ad | | Annapo | 112 | | AIIII | e midilder |
| FUNERAL DIRECTOR | 10e. STATE 10b. COUNTY | Arunde: | L An | r, town or Locat napolis | | | | 10d. INSIDE CITY LIMITS? Y YES 2 NO |
| RAL | 10e. STREET AND NUMBER | 2 d | | | ZIP CODE | | | USA |
| 빌 | 30 Collison Ro | | T EVER IN U.S. ARMED | | | NIC ORIGIN? (Specify | _ | 14. RACE — American Indian, |
| BY FU | 1 Never Merried 2 Married 3 Wildowed 4 Divorced | | YES 2X NO | If yes, epo | | n, Puerto Ricen, etc. | | Specify: White |
| | 15. DECEDENT'S EDUC | | 16a. DECEDENT'S | Work done during mo | ON st of working | 16b. KIND OF | BUSINESS/IN | IDUSTRY |
| | (Specify only highest grade of Elementery/Secondary (0-12) | College (1-4 or 5 | Iffe. Do NOT i | isa retired.) | at or working | | | |
| ᆲ | 12 | 4 | | 1 Teach | er | Bd. | of Ed | lucation |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Ma | den Sumame) | |
| | William D. Col | lison | | | Cora (| Collier | | |
| 8 | 19e. INFORMANT'S NAME (Type/Print) | 110011 | 19b. MAILIN | G ADDRESS (Street e | | | Town, State, Z | Zip Code) |
| 2 | Walter N. Coll | ison J | 20 0 | ollison | Rd Ar | nnapoli | s. MD | 21401 |
| | 20e, METHOD OF DISPOSITION | 15011 0 | 20b. PLACE OF DISPO | | | | | - City or Town, State |
| l l | 1 Buriel 2 Cremetion 3 Remo | val trom State | Cedar E | luff | | Δ | nnano | olis, MD |
| | 21. SIGNATURE OF FUNERAL SPRINCE LICE | DIGEE . | yeuar I | 22. NAME AL | ND ADDRESS OF FA | CILITY | | |
| - 1 | 1 1211 | 1/11 | | Harde | sty Fu | neral H | ome, | P.A. |
| | · Dars | ay | 1 | 12 Ri | dgely . | Avenue, | Anna | apolis, MD |
| | 23. PART I. Enter the disesse, or c | omplications th | et ceueed the death. Do | not sntsr the mo | de of dying, euc | ch sa cerdiec or r | espiratory e | errest, Approximete interval Between |
| - 1 | shock, or heert failure. I | lat only one ca | | | А | | | Onset and Deeth |
| | diseese or condition | | My. | erstul | wherely | ā | | Keur |
| - 1 | resulting in death) | DUE TO | OR AS A CONSEQUENCE | OF): | U | | | |
| _ | - | | | | | | | |
| CERTIFICATION | Sequentielly list conditions, | DUE TO | O (OR AS A CONSEQUENCE | OF): | | | | |
| AT | if sny, leading to immediata cause. Entar UNDERLYING | | | | | | | 1 |
| 윤 | CAUSE (Diseees or injury that initiated evente | DUE TO | O (OR AS A CONSEQUENCE | OF): | | | | |
| E | resulting in death) LAST | 1 | | | | | | |
| 8 | | 1 | | | | | | |
| -4 | PART II. Other significent condition | | | in the underlyin | g cause given in | | S AN AUTOPS' RFORMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| MEDICA | Alzer | mas d | estel | | | | S 2 NO | COMPLETION OF CAUSE OF DEATH? |
| | J | | | | | | | 1 D YES 2 NO |
| 2 | | | | | | | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | · | 26. P | LACE OF DEATH (C | heck only one) | | |
| 2 | EXAMINER? | HOSPITAL: | ☐ ER/Outpatient 3 ☐ DOA | OTHER: | - E Maddana | 8 Other (Specify |) | |
| PHYSICIAN: | 1 TYES 2 NO | 1 Inpatient 2 | | | JURY AT | 28d. DESCRIBE H | | DCCURED |
| | 1 Natural 5 Pending | | Day, Year) | NJURY W | ORK? YES 2 NO | | | |
| ВУ | 2 Accident investigation | 280 DI 400 | OF INJURY — At home, term | | | 281, LOCATION /S | treet and Numi | aber or Rural Route Number, |
| ED | 3 Suicide 8 Could not be 4 Homicide datermined | | g, etc. (Specify) | i, ecreec, ractory, diff | •• | City or Town, | | |
| ETE | | | | | | | | |
| MPLET | (Uneck only / T | | of my knowledge, death occ | | | | | |
| MO | one) 2 MEDICAL EXAMINE | R: On the beals of | examination end/or investiga | ition, in my opinion, | death occured at th | e time, date and ple | e, end due to | o the ceuse(s) and menner as stated. |
| 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | R | | | 29c. LICENSE N | UMBER | 29d. D | DATE SIGNED (Month, Day, Year) |
| 띪 | General Al | mrl. | | | 10018 | 765 | • | 12/3/90 |
| 유 | 30, NAME AND ADDRESS OF PERSON WH | | USE OF DEATH (ITEM 27) (7) | rpe, Print) | 0 | - 1 | 0.00 | |

SEVERNA

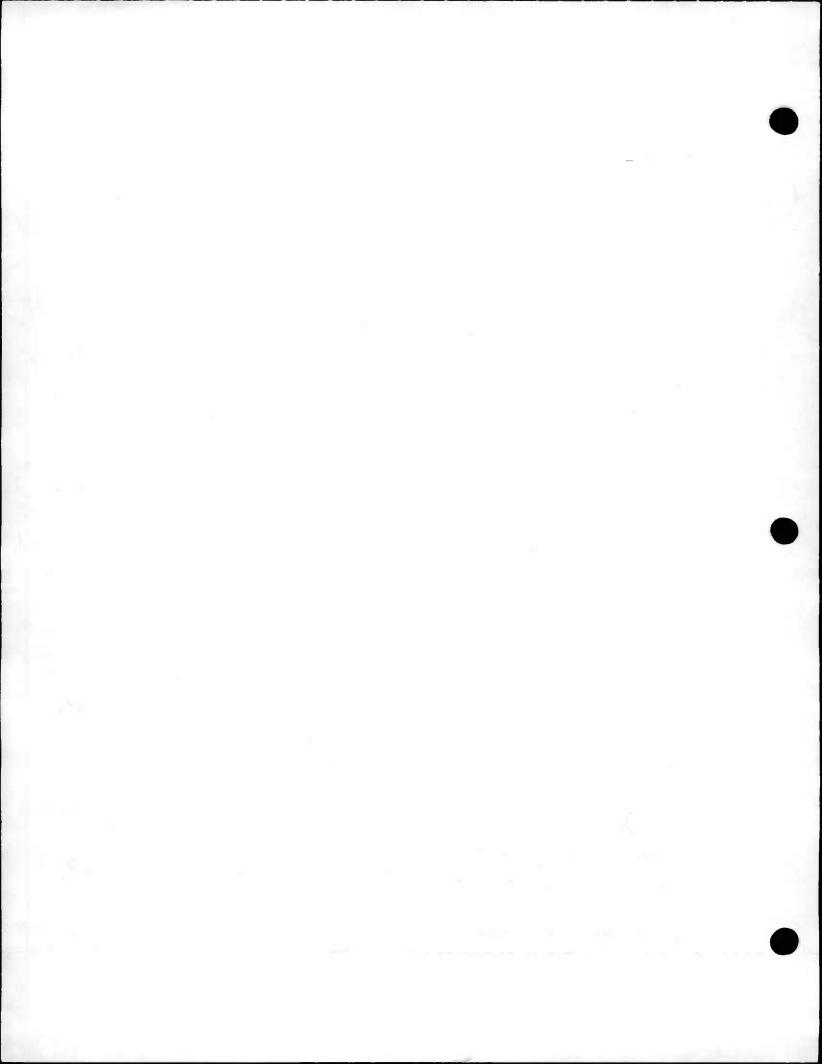
PMK



TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-, nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. In the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE REGISTRAR | STATE OF MARYL | | | HEALTH AND | MEN | REG. NO. | | | |
|---------------|--|--|------------------------|----------------------------------|--------------------------------|----------|-----------------------|------------|------------|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | | | | | 2. [| DATE OF OEATH | , | YEAR | 3. TIME OF DEATH |
| | HARVEY | J • | | COLLISO | N | | 12 0 | | 90 | 02:58 PM M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. last birthday) | IF UNDER 1 YEAR | | 7. 0 | Month, Day, Year) | | 8. BIRTH | PLACE (State or Foreign |
| | 215-09-7736 | 1X M 2 □ F | 85 YRS. | MONTHS DAYE | HOURS MIN. | | 8 24 | 05 | | IRGINIA _ |
| | 9e, FACILITY NAME (If not institution, give | street and number) | | 9b. CITY, TOW | OR LOCATION OF | DEATH | | 9c, COUR | ITY OF O | EATH |
| 8 | NORTH ARUNDEL H | OSPITAL ASSO | CIATION | GLE | N BURNIE | | | | A.A | . COUNTY |
| DIRECTOR | RESIDENCE OF DECEDENT 100. STATE 10b. COUNT | TV. | 40e CIT | Y, TOWN OR LOC | ATION | | | | | 10d. INSIDE CITY |
| Ë | | NNE ARUNDE: | | 1-21-21-2 | | T E3 | | | | LIMITS? 1 YES 2- NO |
| 26 | 10e. STREET AND NUMBER | MNE AKUNDE. | ь | | EN BURN | TE | | 10g CITI | ZEN OF 1 | WHAT COUNTRY? |
| RA I | 604 CRAIN HIG | M D V CMI | | | 2106 | 1 | | 1004 | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEOENT EVER II | NIIS ADMED | 13 WMS II | ECENOENT OF HISP | | RIGIN? (Specify Yea | | U.S | |
| - 11 | 1 Never Merried 2 Merried | FORCES? 1 YES | 2 X NO | If yes, | specify Cuben, Mexi | ican, Pu | | | Spec | E — Americen Indien, k, White, etc. |
| À | 3 Widowed 4 Divorced | IP TES, GIVE WAR ON D | ALES | '''' | ES ZY NO Spe | сну. | | | | HITE |
| 8 | 15. DECEDENT'S EDI (Specify only highest grad | JCATION In completed) | 16a. DECEDENT'S | USUAL OCCUPA work done during | | | 16b. KIND OF BUS | INESS/IND | DUSTRY | |
| ᄪ | Elementary/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT u | se retired.) | most or working | | | | | |
| 린 | 12 | - | OWN | ER | | | LUMBE | ₹ & | BLD | G. SUPPLY |
| COMPLETED | 17, FATHER'S NAME (First, Middle, Last) | | | | | | First, Middle, Meiden | | | |
| BE | JOHN H. (| COLLISON | | | AN | INI) | E COL | LINS | <u> </u> | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | et and Number or Rur | | | | | 21061 |
| - | JOHN H. COLLIS | | | | LN AVEN | | | | | |
| | 20s. METHOD OF DISPOSITION 1.X Buriel 2 Cremetion 3 Ref | moval from State | | | cematery, crematory of EMETERY | | 7.1 | CATION - | | E, MD. |
| 7 | 4 Donation 5 Other (Specify) | IOFNIOTE # 1 | GUEN II | | AND ADDRESS OF | | | и в | 21/11/17 | .п, ги |
| | 21. SIGNATURE OF PURERAL SERVICE L | J Cou | Imeur | RAY | MOND C. | F | INK FUN | ERAI | L HO | ME 21061 |
| | - Jany | 0.1-0 | 0 | 426 | CRAIN | HW | Y.S.W.G | LEN | BUI | RNIE, MD. |
| | 23. PART i. Enter the diseases, or | complications that cause List only ope cause on a | d the deeth. Do | not enter the | mode of dying, s | uch as | cardiec or reapi | iratory en | reat, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final | / / | 1 | -to 1 | THAM | / | | | | Onset and Death |
| | disease or condition resulting in death) | · CRYPEN | 9(| 10m/1 | MUNU | | | | | 120- 40 cm |
| | | DUE TO JOH AS | A CONSEQUENCE | - | 12/2/2 | , | | | | 4010 |
| ON | Sequentially list conditions, | b. UD F V TO 1000 AS | A CONSEQUENCE | ¥7 ' | Uroqu | 11 | | | | Tim |
| TA | if any, leading to immediate ceuse, Enter UNDERLYING | Vest 14 |) | O | | | | | | |
| 윤 | CAUSE (Disease or injury that initiated events | DUE TO (OR AS | A CONSEQUENCE | OP): | | | | | | |
| CERTIFICATION | reaulting in death) LAST | | | | | | | | | |
| | PART II. Other significant condition | one contributing to death | but not requiting | in the under | dog cause given | in Per | t I. 24e. WAS AN | ALITOPSY | 24 | b. WERE AUTOPSY FINOINGS |
| CAL | Contro Symmetry Condition | 7 | A | III tile unuari | ring cause given | Wi Fan | PERFO | RMED? | 1 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDIC | - unfer Irus | HEAV PAN | and | | | | 1 TYES 2 | NO | | OF DEATH? |
| Σ | | 1 000 | 1.01 | | | | - | (| | 1 TYES 2. NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL | | | 24 | . PLACE OF DEATH | /Check | only one) | | | MIN. |
| CI | EXAMINER? | HOSPITAL: | toetleet 3 DOA | OTHER: | Iome 5 Residen | | | | | |
| HYS | 27. MANNER OF DEATH | 86. DATE OF INJURY | 28b. Ti | ME OF 28c. | INJURY AT | - | d. OESCRIBE HOW | INJURY O | CCURED | |
| | 1 Natural 5 Pending | (Month, Day, Year) | " | M 1 | WORK? YES 2 NO | | | | | |
| ВУ | 2 Accident investigation 3 Suicide 6 Could not b | 28e. PLACE OF INJUR | IY — At home, farm | , street, factory, | office | 28 | It. LOCATION (Street | and Number | er or Rura | Poute Number, |
| TEC | 4 Homicide determined | building, etc. (Spi | ecify) | | | | City or Town, State |) | | |
| COMPLETED | 29a. CERTIFIER CERTIFYING PHY | /SICIAN: To the best of my kno | wiedge, death occu | rred at the time. | date end place, end | due to | the cause(e) end me | nner as st | ated. | |
| ME | (Check only | NER: On the basis of examinati | | | | | | | | e(e) and menner as stated. |
| | 296. SIGNATURE AND TITLE OF | ERATA | | <u> </u> | 29c. LICENSE | NUMBE | R | 29d. DA | TE SIGNE | D (Month, Day, Year) |
| BE | TAIR / D | 140 alloha | 1 m | | D-1. | 51 | 760 | 11 | 2- | 3-40 |
| 5 | 30 MASE AND ADDRESS OF PERSON Y | | | | | | | 1 / | | |
| | HILARY T. O'HER | RLIHY, M.D./3 | 25 HOSPI | TAL DRI | VE, SUI | E 2 | 08/GLEN | BURN | IE, | MARYLAND 210 |
| | 31. DATE FILEO (Month, Day, Year) | 32 REGISTRANSSIG | ENATURE | | | | | | | |
| | DEC 0 5 1990 9 | what wandson- | | | | | | | | |



3. TIME OF DEATH

a. BIRTHPLACE (State or Foreign

9c. COUNTY OF DEATH

USA

Wi comi co

10g. CITIZEN OF WHAT COUNTRY?

North Carolina

10d. INSIDE CITY

14. RACE — American Indian, Black, Whita, atc.

Specify: White

WX YES 2 NO

Approximate

10dats

2days

24b. WERE AUTOPSY FINDINGS

OF DEATH? 1 YES 2 NO

28d. DESCRIBE HOW INJURY OCCURED

261. LOCATION (Street and Number or Rural Route Number, City or Town, State)

AVAILABLE PRIOR TO COMPLETION OF CAUSE

intervai Betwe

Onaet end Death

6 hrs.

11:00p.m.m

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examiner

medicai

or other

23 shows any injury,

item 2

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BY

COMPLETED

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9

27. MANNER OF DEATH

5 Pending

6 Could not be

1 X Natural

2 Accident

3 Suicide

4 Homicide

31. DATE FILED (Month, Day, Year)

DEC 0 3 '90

in by the funeral director, page 5 should removal.

filled in by

n and completely filled to burial, cremation, o traumatic event, the

certificate has been signed by the attending physician an the State Dept, of Health and Mental Hyglene prior to

DIRECTOR: After this c hours after death with is marked,

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| 1314 | executed |
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| O. BO | law requires that the death certificate be executed within |
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| u. | AR. |
| Ā | The |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146 | AL OR ATTENDING PHYSICIAN; The la |
| /ISION | ATTENDING |
| \leq | R |
| _ | HOSPITAL |

FOR STATE REGISTRAR CERTIFICATE OF DEATH 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 11/26 / 1990 YEAR Maude Elizabeth Cross 7. DATE OF BIRTH (Month, Day, Year) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 1 M 2 XF 73 YRS. Oct. 8, 1917 217-12-6878 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH Salisbury DIRECTOR Deers Head Center RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10a. STATE Dorchester Hurlock Maryland FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 304 Wrights Avenue 21643 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2XXNO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yas or No-If yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 X Married BY 3 Widowed 4 Divorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY 11 Homemaker 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Sumame) William Filmore Jaynes Zora Anne Craig H 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Lewis M. Cross 304 Wrights Avenue, Hurlock, MD 20e. METHOD OF DISPOSITION
1 № Burlel 2 □ Cremation 3 □ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION - City or Town, State Wicomico Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. SIGNATURE OF PHINTIPAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Zeller Funeral Home Lonn East New Market, Maryland 23 PART / Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition Congestive Heart Failure resulting in deeth) DUE TO (OR AS A CONSEQUENCE OF): Urinary Tract Infection
DUE TO (OR AS A CONSEQUENCE OF): MEDICAL CERTIFICATION Sequentielly list conditions, if eny, leading to immediate Sepsis ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): reaulting in death) LAST 24a. WAS AN AUTOPSY PERFORMED? PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 TYES 2 NO C.O.P.D. PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 TYES 2 NO 4 - Nursing Home 5 - Residence 6 - Other (Specify)

28b. TIME OF

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as attated.

28c, INJURY AT WORK?

2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occurred at the time, data and placa, and due to the ceuse(a) and manner as stated.

1 YES 2 NO

D 33905

28a. DATE OF INJURY (Month, Day, Year)

RESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Dr, Virginia Slacum P.O. Box 2018 Salisbury, Md. 21802

32. REGISTRAR'S SIGNATURE Pandell

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

TO THE HOSPITAL OR ATTO THE FUNERAL DIRECT DE filed within 72 hours a IMPORTANT: If Item 2 10

DHMH-16 Rav 1/89

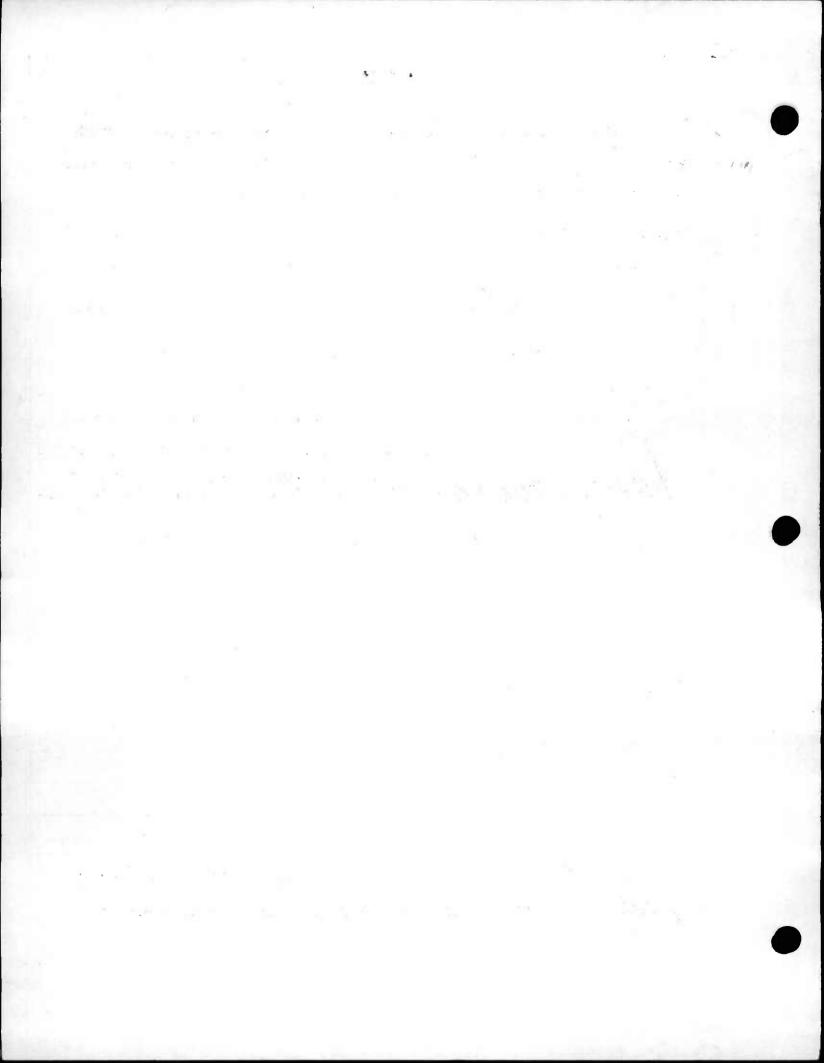
. .

| BALTIMORE, MARYLAND 21203-3146 | HYSICIAN: The law requires that the death certificate be executed within 24 mounts after death. Page 6 may be retained by the hospital or attending physician. | INNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should mith the State Deot, of Health and Merdal Hygiene prior to burial, cremation, or removal. | he medical examiner must be notified at once. |
|--|--|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi he filed within 72 hours after death with the State Deat, of Health and Mental Hyglene prior to burfal, cremation, or removal. | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTMENT | | MENTAL HYGIENE REG. NO. | | |
|--|-----------------------------------|--|--|---|-------------------|---|
| 1. DECEDENT'S NAME (First, Middle, | Last) | | | 2. DATE OF DEATH | YEAR | 3. TIME OF DEATH |
| LEE | FORREST | DENTON | .Tr/ | December 2 | | 8:25P M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | (In yrs. lest birtnday) IF UNDE | 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | THPLACE (State or Foreign |
| 579 40 9202 9e. FACILITY NAME (If not institution, | 1 ⊠ M 2 □ F 57 | YRS. MONTHS | DAYS HOURS MIN. | 3-17-33 | | sh, D.C. |
| | nistration Medi | 2 00 1 | erry Point | EAIR | Gecil | DEATH |
| RESIDENCE OF DECEDEN | | 302 30114. 1 | erry rorme | | GECTI | |
| 10a. STATE 10b. C | OUNTY | 10c. CITY, TOWN | | | | 10d. INSIDE CITY LIMITS? |
| Virginia I | Mecklenburg | GIA | rksville | | | tX YES 2 □ NO |
| Veterans Admin RESIDENCE OF DECEDER 10a. STATE 10b. C Virginia 1 10a. STREET AND NUMBER 50 The Mood 11. MARITAL STATUS | ringe | | 23927-92 | 207 | U.S | WHAT COUNTRY? |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER I | N U.S. ARMED 13. | WAS DECENDENT OF HISPA | | or No. 14. RA | CE - American Indian. |
| 3 Widowed 4 Divorced | | 2 NO | If yes, specify Cuben, Mexic 1 YES 2 NO Speci | en, Puerto Ricen, atc.) | Bla | ock, White, etc. ecity: White |
| 15. DECEDENT' (Specify only highes) | S EDUCATION | 16e. DECEDENT'S USUAL C | | 16b. KIND OF BUS | INESS/INDUSTRY | |
| 15. DECEDENT' (Specify only highes Elementary/Secondary (0-12) 17. FATHER'S NAME (First, Middle, Le | College (1-4 or 5+) | life. Do NOT use retired.) | | | | |
| | 3 years | | Salesman | | | |
| 17. FATHER'S NAME (First, Middle, Le | | | | AME (First, Middle, Melden | | |
| Lee F. | Denton Sr | | | ry H. Thomps | | |
| 190. INFORMANT'S NAME (Type/Print Mary F. Tue | | | S (Street end Number or Rural Moorings, C. | | | 3927-9297 |
| 20a, METHOD OF DISPOSITION | 20 | b. PLACE OF DISPOSITION (N | | | CATION — City or | |
| 1 Burlel 2 Cremation 3 4 Donation 5 Dther (Spycify | Removal from State | other place) | | | | er, Pa.19380 |
| 21. SIGNATURE OF FYRERAL SERV | ICE LICENSEE | 1 11 | NAME AND ADDRESS OF F | ACILITY | | |
| *Anil | 1 Musin | | Lee A. Patte P.O.Box 188 | | | |
| disease or condition resulting in death) Sequentially list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): | och Com | plete heart | block | |
| | nditions contributing to death | but not requiting in the u | nderfylna cause given li | Part I. 24s. WAS AN | ALITTOPRV 2 | 4b. WERE AUTOPSY FINDINGS |
| CAPA COR | | at not resulting in the | indulying cause given in | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| premus | | | | 1 🗆 YES 2 | M NO | OF DEATH? |
| Johnson | THEOHOUTH | | | | | 1 1 165 2 1 10 |
| 25. WAS CASE REFERRED TO MEDI | | | 26, PLACE OF DEATH (C | Check only one) | | - |
| EXAMINER? | HOSPITAL: | patient 3 DOA 4 No | R: Irsing Home 5 🗆 Rasidence | 8 Other (Specify) | | |
| 25. WAS CASE REFERRED TO MEDI EXAMINER? 1 YES 2 X 60 27. MANNER OF DEATH 1 Netural 5 Pendin investig | | 26b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. DESCRIBE HOW I | NJURY OCCURED | |
| A CONTRACTOR | 28e. PLACE OF INJUR | Y — At home, farm, atreet, fa | ctory, office | 281. LOCATION (Street & City or Town, State) | and Number or Run | al Route Number, |
| 0001 | PHYSICIAN: To the best of my know | | | | | e(e) and manner se stated. |
| 296. SIGNATURE AND TITLE OF CE | A D | | 29c LICENSE NI | UMBER -0298 | 29d. DATE SIGN | ED (Month, pay, Year) |
| 30. NAME AND ADDRESS OF PERS | ON WHO COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, Print) | | | | 7120 |
| 1 With | Wh JANET VIT | TONE, M.D., | VA Medical C | enter Dam- | Doint | MD 21002 |

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CERTIFICATION

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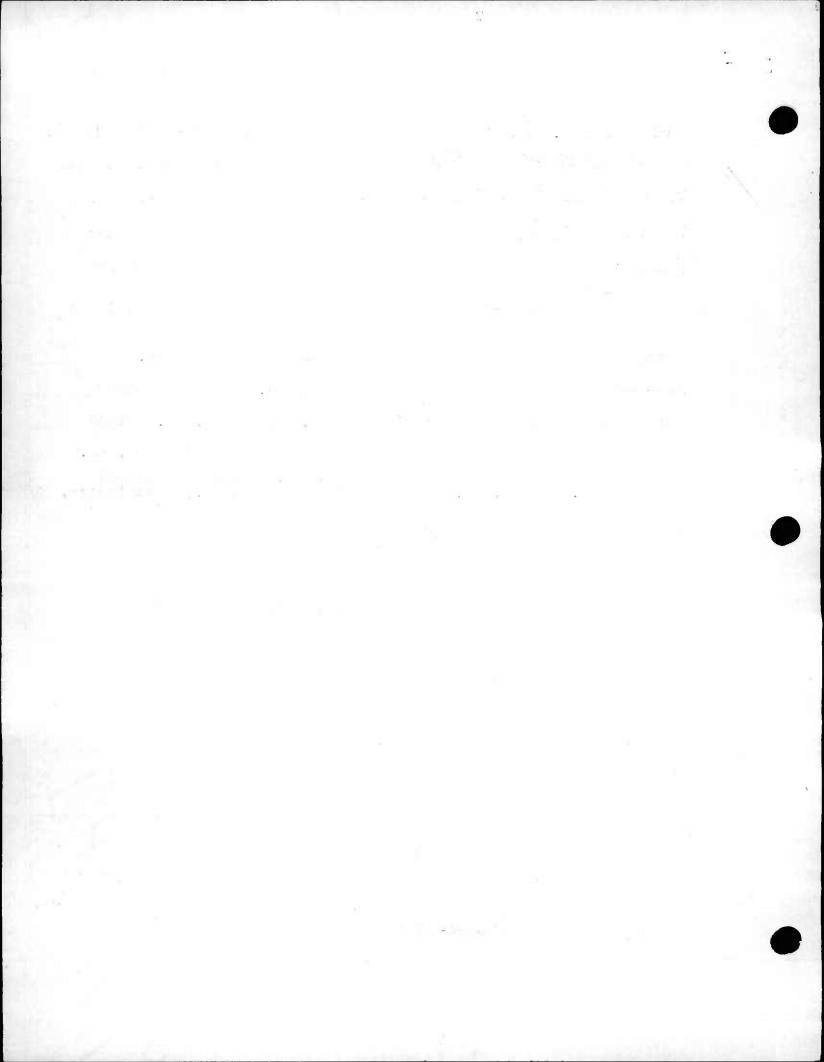
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| F VIIAL | SICIAN: The Is | certificate has | d, or item 2 |
| OF VITAL | PHYSICIAN: The Ia | this certificate has with the State De | rked, or item 2 |
| N OF VITAL | NG PHYSICIAN: The I | fter this certificate has sath with the State De | marked, or item 2 |
| ION OF VITAL | NDING PHYSICIAN: The I | 3: After this certificate has | is marked, or item 2 |
| ISION OF VITAL | TTENDING PHYSICIAN: The I | TOR: After this certificate has after death with the State De | 28 is marked, or item 2 |
| INISION OF VITAL | R ATTENDING PHYSICIAN: The Is | RECTOR: After this certificate has urs after death with the State De | sm 28 is marked, or item 2 |
| DIVISION OF VITAL | L OR ATTENDING PHYSICIAN: The Is | DIRECTOR: After this certificate has bours after death with the State De | item 28 is marked, or item 2 |
| DIVISION OF VITAL | YTAL OR ATTENDING PHYSICIAN: The Is | RAL DIRECTOR: After this certificate has 172 hours after death with the State De | : If item 28 is marked, or item 2 |
| DIVISION OF VITAL | OSPITAL OR ATTENDING PHYSICIAN: The Is | JNERAL DIRECTOR: After this certificate has thin 72 hours after death with the State De | NNT: If Item 28 is marked, or Item 2 |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | E HOSPITAL OR ATTENDING PHYSICIAN: The Is | E FUNERAL DIRECTOR: After this certificate has a within 72 hours after death with the State De | RTANT: If Item 28 is marked, or item 2 |
| DIVISION OF VITAL | THE HOSPITAL OR ATTENDING PHYSICIAN: The Is | THE FUNERAL DIRECTOR: After this certificate has filed within 72 hours after death with the State De | PORTANT: If item 28 is marked, or item 2 |
| DIVISION OF VITAL | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or i | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the me |

34342 FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH -9°C 1 7. DATE OF BIRTH (Month, Day, Year, 3 - 16 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 6. BIRTHPLACE (State or Fore DAYS Ind 9e. FACILITY NAME (If not institution 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH RESIDENCE 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 LITES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 101. ZIP CODE G 10 C 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1, X YES 2 \square NO IF YES, GIVE WAR OR DATES 1919-1927 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No- RACE — American Indian Black, White, etc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen,

1 YES 2 HO Specify: White 3 Widowed 4 Divorced 15. DECEDENT'S EDUCATION 18e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5+) 5th Noxell Co 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) William Day Huddleston 19e, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Raymond Day Fawn Way. Finksburg. Md. 20s METHOD OF DISPOSITION
1 A Burlel 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State Parkwood Cemetery Baltimore, MD. 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AODRESS OF FACILITY Pritts Funeral Home & Chapel Robert K. Pritts. 412 Washington Rd., Westminster, Sr. MD 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. Liet only one cause on each line. Approximete Interval Between IMMEDIATE CAUSE (Final Onset and Death disease or condition reaulting in death) DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF that initiated events reculting in death) LAST PART II. Other algorificant conditions contributing to deeth but not resulting in the underlying ceues given in Part I. 24e. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? Mass. 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** OTHER:
4 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1 | Inputient 2 | ER/Outpetient 3 | DOA 27. MANNER OF OEATH 28e. DATE OF INJURY 28b, TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural м 1 YES 2 NO 2 Accident investigation 28e. PLACE OF INJURY — At home, tarm, street, factory, office building, etc. (Specity) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mennar as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(e) end menner ee stated. 296. SIGNATURE AND TITLE OF CERTIFIER 22609 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B ER 7445 SULNACE



IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND / DEPARTMENT | OF HEALTH AND | MENTAL HYGIENE |
|--------------------------------|---------------|----------------|
| CERTIFICATI | OF DEATH | REG. NO. |

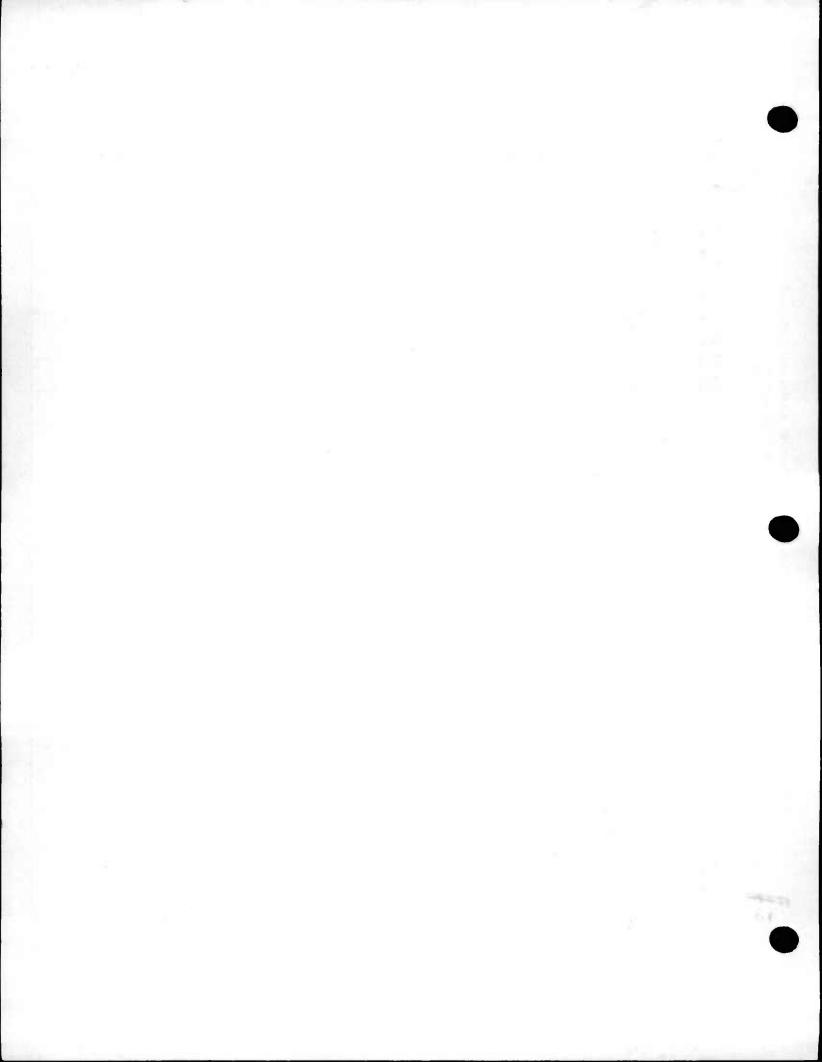
| | 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | | 20 04040 |
|----------------------|---|--|---|------------------------------|-----------------------------|---|------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | Phillip Ja | | ennis, | Sr. | Nov. 25, | 1990 ° | ar 3. TIME OF DEATH 8 A M |
| 1 | 199-09-8530 | 12 M 2 F | 79 YRS. MC | F UNDER 1 YEAR ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day Year) July 2., | 1911 | BIRTHPLACE (State or Foreign Country) |
| TOP | 9e. FACILITY NAME (If not institution, give : Harrison Hou | street and number) tse Nursing | Home | sh. city, town o | Hill, | Md. | WOTC | OF DEATH CSECT |
| FUNERAL DIRECTO | RESIDENCE OF DECEDENT 100. STATE 10b. COUNT WOR | cester | 1 10 00 00 00 0 | OCOMO | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO |
| ERAL | 100. STREET AND NUMBER | Colona Ro | i. | 10f. | 21851 | | 10g. CITIZEN | OF WHAT COUNTRY? |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 YES | 2X NO | 13. WAS DECI | city Cuban, Mexical | IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.) | e or No— 14. | RACE — American Indian, Black, White, etc. Specifielack |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | JCATION s completed) College (1-4 or 5+) | 16e. DECEDENT'S US (Give kind of work life. Do NOT use in Parber | k done durina mos | N at of working | 166. KIND OF BU | | TRY |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) | Samuel Denr | nis | | 18. MOTHER'S NAI | ME (First, Middle, Malden garet Br | Sumame) | igham |
| TO 8 | 190. INFORMANT'S NAME (Type/Print) Anna Turpin | | 196. MAILING AE 203 | Laure | nd Number or Rural F | Ocomoke, | m, State, Zip Co Md | 21851 |
| | 20e. METHOD OF DISPOSITION 1 Strict Burlet 2 Cremetion 3 Rem 4 Donetion 5 Other (Specify) | noval from State | other place) Sa | on (Name of com | etery, crematory or AMES | 20c. LC | COMO K | or Town, State Ce, Md. |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | J. Who | rlon | Whar | | H. Accon | | 23301 |
| CERTIFICATION | 23. PART I. Enter the disease, or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in daath) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. CEREBRI DUE TO (OR AS A DUE TO (OR AS A C. | sach lina. | AR | ACCI DI | | iratory arrest | Approximate Interval Between Onset and Death // WKS |
| PHYSICIAN: MEDICAL C | PART II. Other significant condition | na contributing to deeth b | out not resulting in t | the undarlying | cause given in | Part i. 24a. WAS AN PERFOI 1 YES : | RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| SICIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | ACE OF DEATH (Che | | | |
| | 27. MANNER OF DEATH 1 X Netural 5 Pending | 26e. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | OF 28c. INJU | JRY AT RK? | 28d. DESCRIBE HOW | INJURY OCCUR | ED |
| TED BY | 2 Accident Investigation 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, ferm, stre | et, factory, office | | 281. LOCATION (Street City or Town, State) | and Number or | Rural Routa Number, |
| COMPLETED | | ICIAN: To the best of my know ER: On the basic of examination | | | | | | suse(s) and manner se stated. |
| TO BE C | | 1. Advorth | m.S. | | 29c. LICENSE NUM | | | IGNED (Month, Day, Year) |
| 1 | 30. NAME AND ADDRESS OF PERSON WE DESCRIBE THY 31. DATE FILED (Month, Day, Year) | HO COMPLETED CAUSE OF DE HOLZ LISO Z. 32. REGISTRAR'S SIGN | ATH (ITEM 27) (Type, Pri | int) | EZISON | HUSE | SNOW | HILL, MD, |
| 41 | DEC U 7 100 | Selia Navida | A Branda DO | | | | | |

. .

TO BE COMPLETED BY FUNERAL DIRECTO

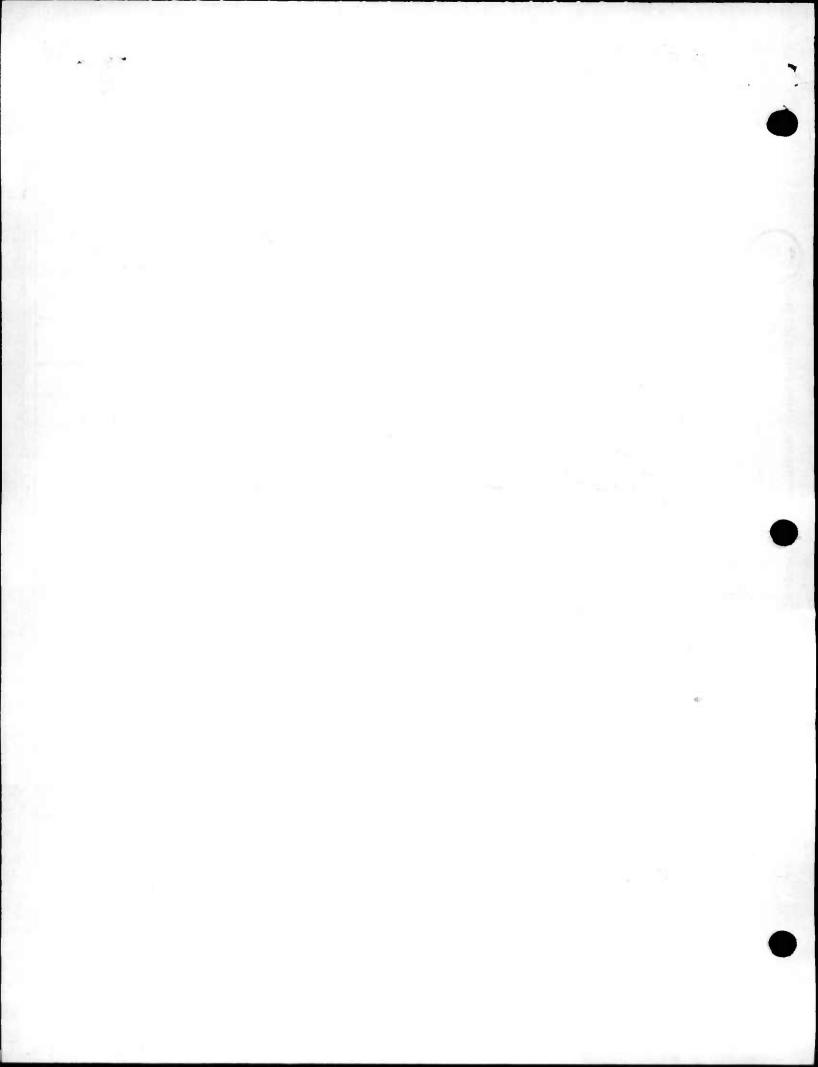
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL HYGIEN | | ० उप्रदेश |
|--|--|--|------------------------------|--------------------------------|--|-------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last |) | | | | 2. DATE OF DEATH | AV MEAN | 3. TIME OF DEATH |
| | OHN FRANK | Dods | on | | November | 26 1990 | 10:02AM |
| 214-07-8227 A | 1) M P. F 91 | r yrs. last birthday) IF U | INDER 1 YEAR THE DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) Sept. 2, | 6. BIRT | HPLACE (State or Foreign |
| 9a. FACILITY NAME (If not institution, given Memorial Hosp | ital | | aston | LOCATION OF DE | ATH | 9c. COUNTY OF Talbot | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | | 10c. CITY, TO | WN OR LOCATI | ON | | | 10d, INSIDE CITY |
| Maryland Quee | n Anne | Quee | n Ann | ZIP CODE | | 10a. CITIZEN OF | LIMITS? 1 ☐ YES 2 ☑ NO WHAT COUNTRY? |
| Crouse Mill 5 |) o o d | | - N | 21657 | | USA | 03111 |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Vidowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2-Z NO | 13. WAS DECE If yes, spe- | NDENT OF HISPAN | IC ORIGIN? (Specify Yen, Puerlo Ricen, atc.) | a or No- 14, RAG Ble | CE — American Indian, ck, Whits, atc. chy: White |
| 15. DECEDENT'S EC | IUCATION de completed) | 18a. DECEDENT'S USUI (Give kind of work of life. Do NOT use reti | AL OCCUPATION | of working | 16b. KINO OF BU | SINESS/INDUSTRY | |
| Elementary/Secondary (0-12) 4 years | College (1-4 or 5+) | watchma | | | Nat,1. | Can Co | o • |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Malden | Surname) | |
| John Thomas I | odson | | | | Vane | | |
| 19a. INFORMANT'S NAME (Type/Print) | 1 | | | | loute Number, City or Tow | | |
| Gilbert F. Do | | PLACE OF DISPOSITION | ace S | t . Cambi | ridge. Mo | CATION — City or | |
| 5 Buriel 2 Cremation 3 Re 4 Donation 5 Other (Specify) | moval from State | reen Law | | | 200. 20 | | dge, Md. |
| 21. SIGNATURE OF FUNERAL SERVICE I | | reen baw | | ADDRESS OF FAC | CILITY | Cumbili | ige, iid. |
| 1 Kan 555 | R Thomas Gr | | | | homas Fu | | Md. 21613 |
| 23. PART I. Enter the diseases, or ahock, or heert fellure IMMEDIATE CAUSE (Finel disease or condition resulting in death) | s. Charles on as | the deeth. Do not each line. Consequence of: | eat | failu | n es cerdiec or reep | iretory arrest, | Approximeta Interval Between Onset and Desth |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | · com | consequence of: consequence of: consequence of: | teg tre | diseas | e + lu | sperteus Dan d | in tys. |
| PART II. Other significant condition | ONTWU | | | | | RMED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ОТ | 26. PL | ACE OF OEATH (Che | ock only one) | | |
| 1 VES 27 NO | 1 Ninpetient 2 - ER/Output | atlant 3 DOA 4 D | Nursing Home | | 6 Other (Specify) | IN HERY ACCURE | |
| 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | 28b. TIME OF INJURY | M 1 🗆 Y | ES 2 NO | 28d. DEŞCRIBE HOW | | |
| 3 Suicide 6 Could not b | e 28e. PLACE OF INJURY building, etc. (Speci | — At home, farm, street | t, factory, office | × | 28f. LOCATION (Street City or Town, State | and Number or Rura) | I Route Number, |
| torson only 11 | SICIAN: To the best of my knowledge. NER: On the basis of examination | | | | | | o(a) and manner as stated. |
| 296. SIGNATURE AND TITLE OF CERTIF | auter | 10 | | 29c, LICENSE NUM | 1824 | | 26/90 |
| 30. NAME AND ADDRESS OF PERSON V | DANICINS | 312 | () | EAST | S IDLEW | JILD WI AND | 21601 |
| 31. DATE FILED (MONTH PAY 28 19) | 32. REGISTIAN'S SIGN | ATURE Handel | 201 | | | | |



| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | BALTIMORE, MARYLAND 21203-3146 |
|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Jurs after death. Page 6 may be retained by the hospital or attending physician | Aurs after death. Page 6 may be retained by the hospital or attending physican |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial to burial, cremation, or removal. | in by the funeral director, page 5 should be detached for use as the burial through permit or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | nedical examiner must be notified at once. |

| REGISTRAR | OTATE OF MAC | CERTIFIC | | | MENTAL HYGII REG. I | | | | | |
|--|--|--|--|--|---|-----------------------|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Las | · | | | | 2. DATE OF DEATH | DAY 1 0 0 X | 3. TIME OF DEATH | | | |
| Freda Anna | | GE (In vrs. last birthday) # | UNDER 1 YEAR | IF UNDER 24 HRS. | NOV. 29 | | | | | |
| 215-12-7244 | 5. SEX 6. A | BIRTHPLACE (State or Foreign Country) Principio, N | | | | | | | | |
| 9a. FACILITY NAME (If not institution, give | | 80 YRS. | CITY TOWN | OR LOCATION OF D | 5/30/1 | | OF DEATH | | | |
| | | | Elkt | | EATH | Cec | | | | |
| 10a. STATE 10b. COUN | 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. | | | | | | | | | |
| Maryland Cec | Cecil -Elkton North East | | | | | | | | | |
| | 417 Rolling Mill Lane 101. ZIP CODE 21901 U.S | | | | | | | | | |
| Union Hospita RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Cec 10c. STREET AND NUMBER 417 Rolling 11. MARITAL STATUS 1 Never Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EV. FORCES? 1 1 1 | ES 2 NO | If yes, sp | ENDENT OF HISPA ecify Cuban, Mexico 2 NO Speci | NIC ORIGIN? (Specify an, Puerto Rican, etc.) y: | Yea or No— 14 | RACE — American Indian, Black, White, etc. Specify: White | | | |
| 15. DECEDENT'S Et (Specify only highest gra | DUCATION ade completed) | 16a. DECEDENT'S US | done during mo | | 18b. KIND OF | BUSINESS/INDUS | | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) N/A | Homem | , | | H | lome | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maid | den Sumame) | | | | |
| Harry C. Jo | nes | | | Susi | e Tilgh | man | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING AD | DRESS (Street a | nd Number or Rural | Route Number, City or | Town, State, Zip Co | ode) | | | |
| Betty A. Barr | | 8 Blyt | hedal | e Rd. I | Perryvil | le, MD | 21903 | | | |
| 20a. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Re | movel from State | 36b. PLACE OF DISPOSITA | | | | LOCATION — CIT | | | | |
| 4 Donation 5 QMM (Specify) | 1 | orth East | The Party of the P | | | rth Ea | st, MD | | | |
| · Moled | 0-6 | | Crou | | eral Hom | | st, MD 219 | | | |
| immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediats cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO (OR) | MRDIA! JVF AS A CONSEQUENCE OF): | ARE TIO | ~ | | | Interval Between | | | |
| PART II. Other significent condition | d | th but not resulting in t | hs underlyin | j ceuse given in | Part I. 24a. WAS PERI | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO | | | |
| | | | | | 1 YES | 2 <u>X</u> NO | COMPLETION OF CAUSE OF DEATH? 1 YES 2 XNO | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | ACE OF DEATH (C) | eck only one) | | | | | |
| 1 TYES 2 NO | 1 Inpetient 2 ER/ | | THER: Nursing Hom | e 5 🗆 Residenca | 6 Other (Specify) | | | | | |
| 27. MANNER OF DEATH | 28a. DATE OF INJU (Month, Day, Ye | RY 26b. TIME O | WO | RK? | 28d. DEŞCRIBE HO | W INJURY OCCUP | RED | | | |
| 1 Natural 5 Pending Investigation 2 Accident I | | | | | | | | | | |
| 2 Accident Investigation 3 Suicide 6 Could not b | | | | | to the council and | | | | | |
| 2 Accident 3 Suicide 6 Could not b 4 Homicide 6 Certifying PHY (Check only 1 CERTIFYING PHY | /SICIAN: To the best of my k | | | | | | | | | |
| 2 Accident 3 Suicide 6 Could not b 4 Homicide 6 Certifying PHY (Check only 1 CERTIFYING PHY | /SICIAN: To the best of my k | | | eath occured at the | time, data and placa, | and due to the c | ause(a) and manner as stated. | | | |
| 2 Accident 3 Sulcide 4 Homicide 20a. CERTIFIER (Check only one) 2 MEDICAL EXAMI 29b. SIGNATURE AND TITLE OF CERTIF | /SICIAN: To the best of my k NER: On the basis of examin | action and/or investigation, i | n my opinion, d | | time, data and placa, | and dua to the c | | | | |
| 2 Accident 3 Sulcide 4 Homicide 6 Could not b determined 29a. CERTIFIER (Check only One) 2 MEDICAL EXAMI | /SICIAN: To the best of my k NER: On the basis of examin IER WHO COMPLETED CAUSE OF | eation and/or investigation, is considered and or investigation. | n my opinion, d | 29c. LICENSE NU D - 3239 E | time, data and placa, | 29d. DATE S | ause(a) and manner as stated. IGNED (Month, Day, Year) | | | |



for use as the burfal-transit

page 5 should

76

must

medicai examiner

6

Donald M. Was, NO-

31. DATE FILEO (Month, Day, Year)

32. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

in by the f

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| 11 | N: Th | State | item. |
| . VIT | SICIAN: Th | certificate the State | , or item |
| OF VITA | HYSICIAN: Th | his certificate with the State | ked, or item |
| N OF VITA | NG PHYSICIAN: Th | ther this certificate I | marked, or item |
| ION OF VITA | NDING PHYSICIAN: Th | 3; After this certificate In death with the State | is marked, or item |
| ISION OF VITA | TTENDING PHYSICIAN: Th | CTOR: After this certificate after death with the State | 28 is marked, or item |
| DIVISION OF VITA | OR ATTENDING PHYSICIAN: Th | DIRECTOR: After this certificate I | item 28 is marked, or item |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | ITAL OR ATTENDING PHYSICIAN: Th | SAL DIRECTOR: After this certificate 72 hours after death with the State | if Item 28 is marked, or item |
| DIVISION OF VITA | DSPITAL OR ATTENDING PHYSICIAN: Th | INERAL DIRECTOR: After this certificate Inthin 72 hours after death with the State | INT: if item 28 is marked, or item |
| DIVISION OF VITA | E HOSPITAL OR ATTENDING PHYSICIAN: Th | E FUNERAL DIRECTOR; After this certificate I within 72 hours after death with the State | RTANT: If Item 28 is marked, or item |
| DIVISION OF VITA | THE HOSPITAL OR ATTENDING PHYSICIAN: The | THE FUNERAL DIRECTOR: After this certificate I filed within 72 hours after death with the State | IPORTANT: If Item 28 is marked, or item |
| DIVISION OF VITA | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within z- | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely fills be filed within 27 hours after death with the State Deat, of Health and Mental Horiene prior to burfal, cremation, | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH 2. DATE OF DEATH DAY 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATN YEAR Davis 1430 December 4 JOHN 199. 4. SOCIAL SECURITY NUMBER 5 SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTN (Month, Day, Year) 8. BIRTNPLACE (State or Foreign 218-05-8580 DAYS 1 M 2 - F 84 Nov.12,1906 Virginia 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR PENINSULA GENERAL HOSPITAL SALISBURY, MD WICOMICO RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION toe. STATE 10b. COUNTY 10d. INSIDE CITY Maryland Pocomoke 1 X YES 2 | NO Worcester FUNERAL 10e, STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 614 Clarke Avenue 21851 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-12. WAS DECEDENT EVER IN U.S. ARMED 14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexican, Puerto Rican, atc.)

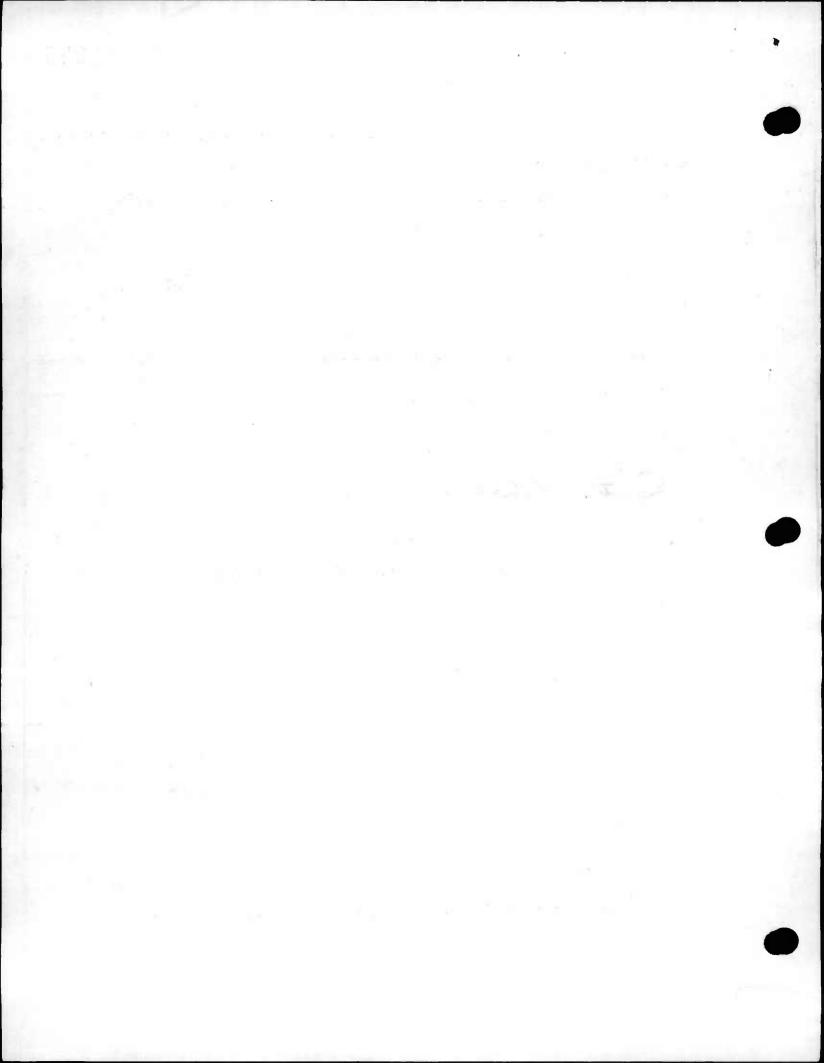
1 YES 2 NO Specify: FORCES? 1 TYES t Never Married 2 Married IF YES, GIVE WAR OR DATES BY Specify: 3 Widowed 4 Divorced white COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 18a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) poultry hight wa feeder and 17. FATHER'S NAME (First, Middle, Last) ta. MOTNER'S NAME (First, Middle, Maiden Surname) John W. Davis, BE Martha Ann Tyler notified a 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zio Code) 2 Lottie Shrieves Davis 614 21851 Clarke Avenue, Pocomoke, Md. pe 20s. METNOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION --- City or Town, State Nelson Pocomoke, Md. Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY MELSON FUNERAL HOME P. O. Box 64, Pocomoke, Md& 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each lina. Approximate intervei Between **IMMEDIATE CAUSE (Fine) Onset and Death** Conchae aunt disease or condition MWS resulting in death) OUE TO (OR AS A CONSEQUENCE OF): Interiosclaria Cardiolasculas Strem YILB CERTIFICATION Sequentially list conditiona, DUE TO (OR AS A CONSEQUENCE OF): If eny, leading to immediate cause. Entar UNDERLYING CAUSE (Diseesa or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in desth) LAST PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. PHYSICIAN: MEDICAL 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS Chronic Conjutive Heart Farline AVAILABLE PRIOR TO COMPLETION OF CAUSE t ☐ YES 2 ☐ NO Certholanden Annymy OF DEATH? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATN (Check only one) OTHER: 1 TES 2 NO 1 | Inpetient 2 | ER/Outpetient 3 | DOA 4 Nursing Nome 5 Realdence 6 Other (Specify) 27. MANNER OF DEATN 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 26c. INJURY AT WORK? 28d. OESCRIBE NOW INJURY OCCURED t Natural 5 Pending BY t YES 2 NO 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f, LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 6 Could not be 4 Homicide determined 29a. CERTIFIER

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(e) and manner as stated. 2 MEDICAL EXAMINER: On the beals of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER

WWW. M. ~ 29c. LICENSE NUMBER 29d. DATE SIGNEO (Month, Ony, Year) BE any ND W3311 12/4/90 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)

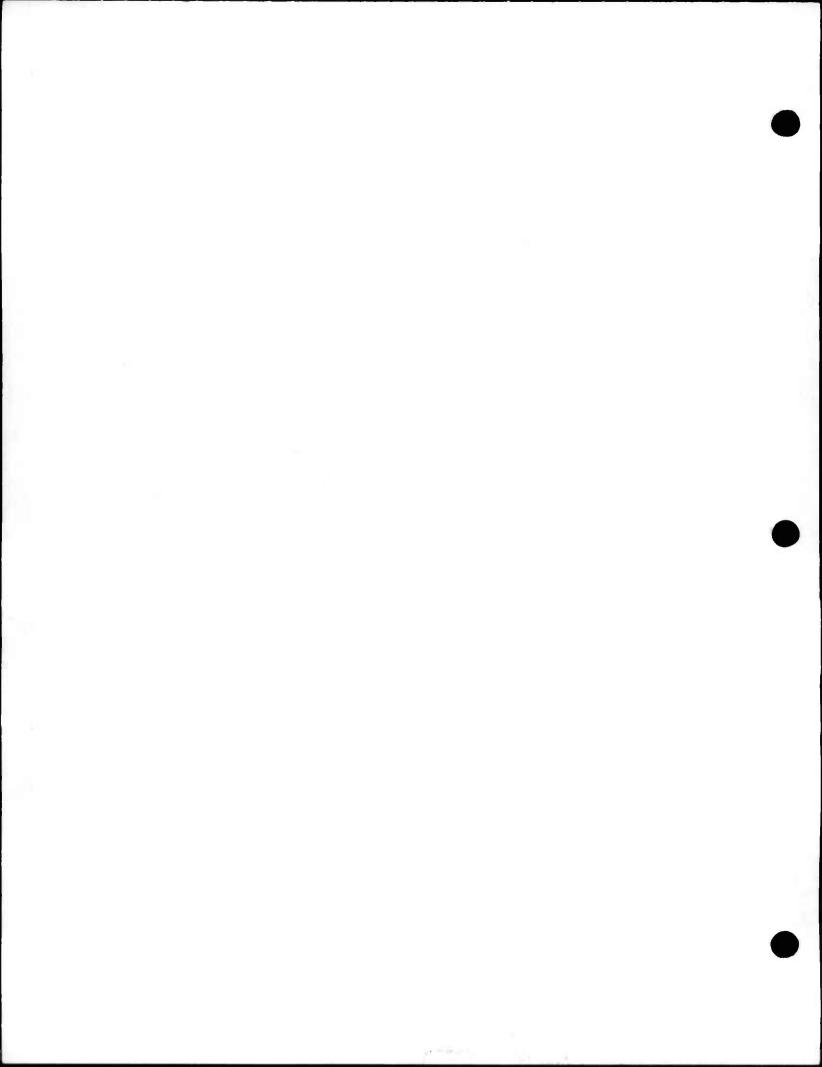
Quincy +Locust Sal Md 21801

DHMH-16 Rev 1/89



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|
|--|--|

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | | YGIENE REG. NO. | | | |
|----------------------|---|---|---|---------------------------------|---|-------------------------------|---|-------------|------------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) NORMA | J. D | ULEY | | | 2. DATE OF MONTH Novemi | | 198 | | ME OF DEATH 3:27 PA |
| | 4. SOCIAL SECURITY NUMBER 577-32-4025 98. FACILITY NAME (If not institution, give si | 1 □ M 2 🟋 F 6: | 1 YRS. | F UNDER 1 YEAR WONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF (Month, Date 4-7- | BIRTH ay, Year) 1929 | L | ountry) uray, | E (State or Foreign Virginia |
| CTOR | SOUTHERN PRESIDENCE OF DECEDENT | md Hos | PITE | CLIN | TON | EATH | P | | OF DEATH | Georges |
| FUNERAL DIRECTOR | Maryland Princ | | rt Wash | | | | 10d. INSIDE CITY LIMITS? 1 ☐ YES 2 🛣 NO | | | |
| NERA | 11411 Rosalie Dr | | | | 20 | 744 | | | U | S.A. |
| B | 11. MARITAL STATUS 1 Never Married 2 🖔 Married 3 Wildowed 4 Divorced | 12. WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 5 V MO | If yes, sp | ENDENT OF HISPAR ecify Cuban, Maxica 2 X NO Specify | n, Puarto Rica | | 0— 14. | RACE — A Black, Whi Specify: | merican Indian, ta, etc. White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) | | ork done during mo retired.) | st of working | | nd of Busines | | | : 26 |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | ACC | ountant | 16. MOTHER'S NA | _ | | | VET. | rer |
| BE C | | R. Griffith | | | | | ette V. | | | |
| 2 | 19a. INFORMANT'S NAME (Typo/Print) Carter G. Duley | | | | nd Number or Rural ie Drive | | | | , | 207// |
| | 20a_METHOD OF DISPOSITION 1 | cumi tram State | b. PLACE OF DISPOSITE Other place) Columbia | TION (Name of cen | netery, crematory or | | 20c. LOCATIO | ON — City | or Town, S | teta |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | | COTUMBLE | Georg | e P. Kal | as Fur | neral H | lome | | |
| | 23. PART I. Enter the diseases, or cahock, or heart fellure. IMMEDIATE CAUSE (Final disease or condition resulting in deeth) | Liet only one ceusa on e | UTE MY | ot enter the mo | de of dylng, suc | h aa cardled | or respirator | ry erreet, | | Approximete Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditione, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Due to (or as A | A CONSEQUENCE OF) A CONSEQUENCE OF) | RY X | RTER | Y | ISEA | ie | | |
| SERT | resulting in death) LAST | d | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other algnificent condition | e contributing to death be ERTEN | | the underlying | ceuse given in | | e. WAS AN AUTO PERFORMED YES 2 X | ? | COM OF D | E AUTOPSY FINDINGS ABLE PRIOR TO PLETION OF CAUSE EATH? YES 2 \(\subseteq \) NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (Ch | eck only one) | | | | |
| YSIC | 1 TES 2 NO | HOSPITAL: 1 ☐ Inpetient 2 X ER/Out | petiant 3 DOA | OTHER: 4 Nursing Hom | a 5 🗆 Realdance | 6 Other (S | pecify) | | | |
| ву Рн | 27. MANNER OF DEATH 1 X Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME INJU | M 1 🗆 Y | RK? /ES 2 NO | 28d. DESCR | IBE HOW INJUR | Y OCCUR | ED | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Spec | Y — At home, farm, at icify) | reet, factory, offic | | 26f. LOCATION City or 7 | ON (Street and Nown, State) | lumber or F | Rural Route | Number, |
| COMPLETED | one) 2 MEOICAL EXAMINE | ICIAN: To the best of my know IR: On the basis of examination | | | | | | | suse(a) and | manner as stated. |
| TO BE | 29b. SIGNATURE AND JUTLE OF CERTIFIER | elm | | | DI30 | MBER 72 | 296 | DATE SI | GNED (Mon | th, Day, Year) |
| _ | | 0. 8926 | Woody | ARD 1 | ed, c | LIN | tow, | m | <i>(</i> . | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | NATURE | | | | | | | |



OHMH-18 Ray 1/89

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-TH

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

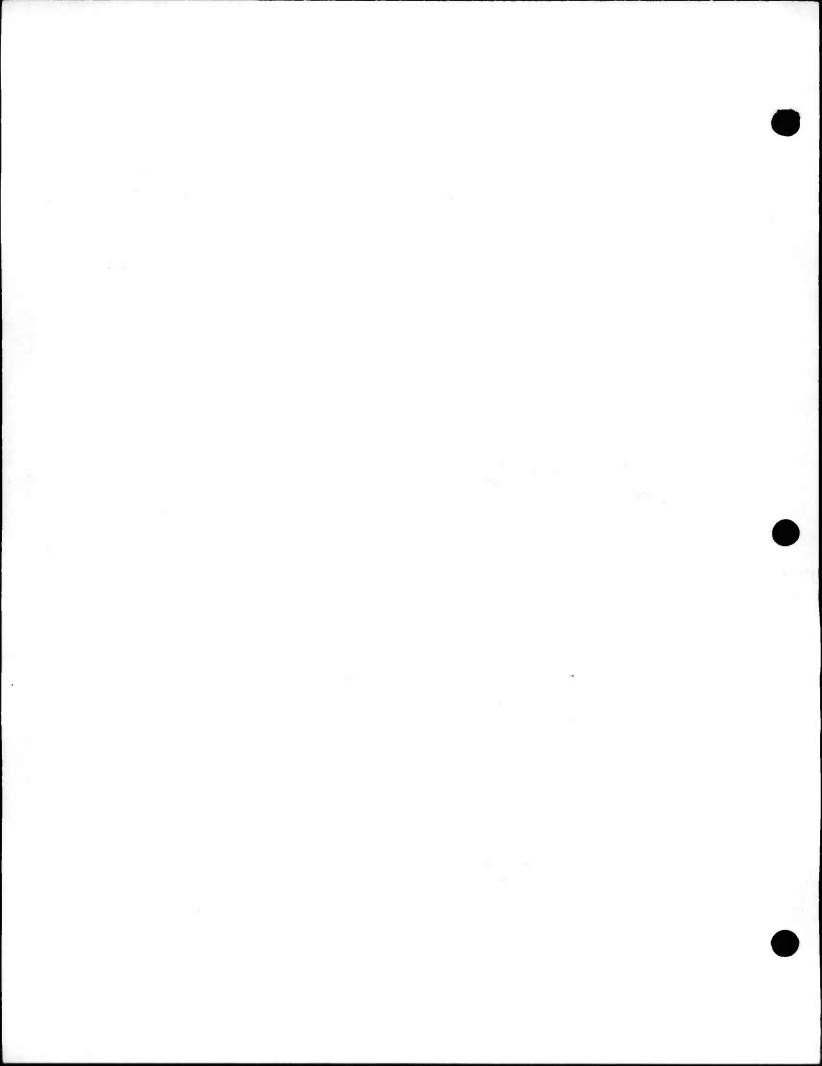
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146 ours after death. Page 6 may be retained by the hospital or attending physician.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO.

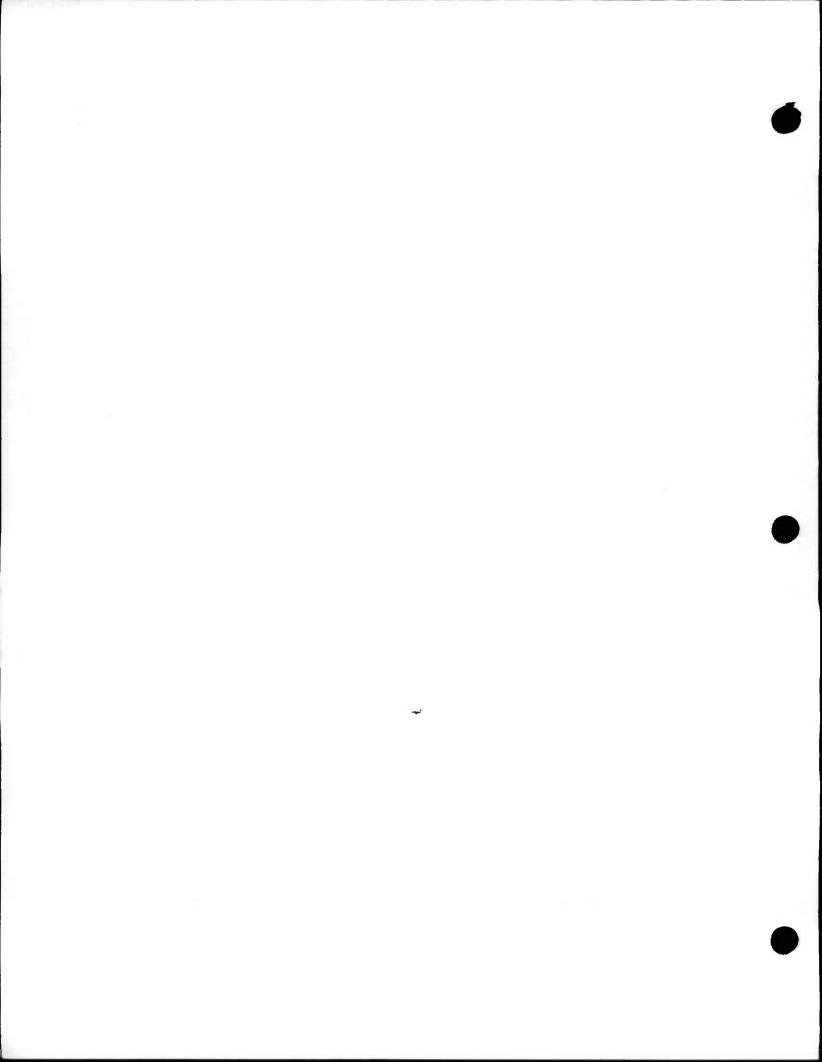
| REGISTRAR | | | С | ERTIFIC | CATE OI | F DEATH | | REG. NO. | | | |
|---|--|--|---------------------------|--|---|--|-----------|--|--|------------|--|
| 1. DECEDENT'S NAME (First, RAL | PH | Francis | DE | SARI | NO | | MON | | | YEAR 90 | 3. TIME OF DEATH A |
| 4. SOCIAL SECURITY NUMBE 579–18–5698– | $579-18-5698-A$ $1 \boxtimes M 2 \square F$ 69 YRS. MONTHS OAYS HOURS MIN. 0×10^{-1} | | | | | | | | | | |
| 90. FACILITY NAME (If not ins | MAK | RYLAND | Hosp | | b. CITY, TOWN | OR LOCATION OF E | DEATH | | | VCE | |
| | 106. COUNTY Prince George's 106. CITY, TOWN OR LOCATION Forestville, Maryland 10d. INSIDE CITY LIMITS? 1 □ YES 2 □ XNO | | | | | | | | | LIMITS? | |
| 100. STREET AND NUMBER 2708 Phel | ps Ave | enue | | | | 20747 | | | 10g. CITI | U.S. | VHAT COUNTRY? A. |
| 3 Mildowed 4 Divorced IF YES, GIVE WAR OR DATES 1 YES 2 MO Specify: Specify: | | | | | | | | Speci | - American Indian, t, White, etc. fy: asian | | |
| 15. DECE (Specify only Elementery/Secondery (0-1 | DENT'S EOUC highest grade | completed) | (0 | ECEDENT'S US Give kind of work B. Do NOT use n | k done during n | TION nost of working | 16 | 6b. KIND OF BUS | | | ADICII |
| 8th | | College (1-4 or 5+) N/A | Fir | reman | | | | Federa | 1 Avi | iatio | on |
| 17. FATHER'S NAME (First, Mice Raffaele | ddle, Last) DiSar | mo | | | | 18. MOTHER'S N Rose | | Middle, Malden | | | |
| 19e. INFORMANT'S NAME (Typ | pe/Print) | | 19 | | | and Number or Rural | | | | Code) | |
| John H. D | | | | | ne as : | | | | | | |
| 20a METHOD OF DISPOSITIO 1 (2 Burlet 2 Cremation 4 Donation 5 Other (| | of DISPOSITION OF DIS | | | 20c. LOCATION — City or Town, State Clinton, Maryland | | | | | | |
| 21. SIGNATURE OF PUNERAL | SERVICE LICI | Note of the last | 3 | | | AND AGORESS OF FA | | | | | ome, Inc, inton, Md 20 |
| 23. PART I. Enter the disabock, or her immediate CAUSE (Final disease or condition resulting in death) Sequentially list condition if eny, leading to immediate ceuse. Enter UNDERLYIN CAUSE (Disease or injury that initiated events resulting in death) LAST | ona, lata | DUE TO (OR | AS A CONSE | ovence of: | | asker, | | | | | Approximate interval Between Onast and Deeth 36 km s. |
| PART II. Other algolifican Chai | at conditions | Rainy & Current for Declar | th but not i | reaulting in t | enia | ng causa given in | Part I. | 24s. WAS AN A PERFORI | MED? | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO EXAMINER? | | HOSPITAL: | | | THER: | PLACE OF DEATH (C | | | | | |
| 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 P | ending | 1 Inpatient 2 I ER/ 28e. DATE OF INJU (Month, Day, Ye | IRY | 28b. TIME OF | F 28c. IN | JURY AT ORK? YES 2 NO | T - | er (Specify) | JURY OCC | UREO | |
| 3 Suicide a C | ould not be | 28e. PLACE OF INJ building, etc. | IURY — At ho (Specify) | ome, farm, atree | | | 28f. LO | CATION (Street ar y or Town, State) | nd Number | or Rural R | oute Number, |
| 29e. CERTIFIER (Check only one) 1 CERTIF | FYING PHYSIC | IAN: To the best of my it: On the basis of examin | nowledge, de | esth occurred a | nt the time, det n my opinion, | e end plece, end due death occurad at the | to the co | e end plece, end | ner ee atate | ed. | end manner as stated. |
| 296, SIGNATURE AND TITLE C | | J. Ser | ford | you | no | 29c. LICENSE NU | | | 29d. DATE | SIGNED | (Month, Day, Year) |
| 30. NAME AND ADDRESS OF I | Young, | MD 11701 | Livin | M27 (Type, Prin 19ston | Road # | #101 Ft, | Wash | nington | , Md | 2074 | 14 |
| 31. DATE FILEO (Month, Day, Ye NOV 2 9 90 | er) | 32. REGISTRAR'S S | | | | | | J | - 177 | | |

Medical Examiner has been notified and this has been approved



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| OSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be reta | JNERAL OIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 st | 2 |
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| | | FOR STATE REGISTRAR | | STATE OF I | MARYLA | | | | EALTH AND I | MENTA | L HYGIE | | 90 | 34 | 349 |
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| | | 1. DECEDENT'S NAME (First, | | - X | | 1 10 | | | | 2. DATE | OF DEATH | DAY | YEAR | 3. TIME OF DE | ATH |
| | | Cather | | E. Dowell | | | | | 11 | | 19 | 90 | 0807 | A.M | |
| | | 4. SOCIAL SECURITY NUMB | BER | 5. SEX | | yrs. last birthday) YRS. | IF UNDER | 1 YEAR DAYS | HOURS MIN. | (Mont | OF BIRTH | 1010 | Counti | | |
| | | 578-24-3785 90. FACILITY NAME (If not in: | etitution also et | 1 M 2 XF | 71 | Tho. | ah CITO | (TOWN C | OR LOCATION OF DI | | 27, | | NTY OF D | irginia | |
| | DIRECTOR | Ft Meade Arm | ny Hosp | an an area. | | | 100 | Mea | | | | | | runde1 | |
| | EC. | 10e. STATE 10b. COUNTY 10e. CITY, TOWN OR LOCATION | | | | | | | | | | | 10d. INSIDE CI | TY | |
| | | None | None | | | | | | | | 1 | | | | _ NO |
| | FUNERAL | 10e. STREET AND NUMBER | | | | | | | . ZIP CODE | | | | | WHAT COUNTRY | ? |
| ian. transi | N N | 3005 25th S | treet, | N.E. | IT EVED IN | US ABMED | 12 | | 20018 ENDENT OF HISPAI | NIC OBION | M2 (P===16.) | | | States | ella- |
| the state of | BY FU | 1 Never Married 2 3 Widowed 4 Divo | | FORCES? 1 YES 2 XNO IF YES, GIVE WAR OR DATES If yes, specify Cuben, Maxico 1 YES 2 XNO Specific | | | | | | nn, Puarto | | THE OF NO. | Spec | E — Amarican in k, White, atc. My: White | cian, |
| 203- | | | EDENT'S EDUC | | | 16a. DECEDENT' | work done | during mo | ON est of working | 168 | , KIND OF E | USINESS/INC | USTRY | | |
| 212 tal or for u | COMPLETED | Elementary/Secondary (0 | 1 | College (1-4 or 5 | +) | ille. Do NOT | use retired.) | | | | | | | | |
| AND he hospit detached | MP | 12 17. FATHER'S NAME (First, M | Veletto (cat) | | | Man | ager | | 18. MOTHER'S NA | NAS (Since | | Servi | Lce | | |
| MARYL retained by 5 should be | | Walter W. T | | + | | | | | Bertha | | | | | | |
| | 8 | 19a. INFORMANT'S NAME (7) | | | | 19b. MAILIN | G ADDRES | S (Street a | and Number or Rural | | | | Code) | | |
| | 2 | Linda Barbo | ur | | | 8410 | Ravei | nswoo | od Road, | New | Carr | olton, | Maı | cyland | 20784 |
| E, Inay be | | 20a. METHOD OF DISPOSITE | | wel from State | 20b. | | | | metery, crematory or | | | LOCATION — | | | |
| MORE age 6 ma director, p | | 4 ☐ Donation 5 ☐ Other | (Specify) | | | | | | Cemetery | | | Warrer | nton | , Virgi | nia |
| SALTII r death. F e funeral al. examin | | 21. SIGNATURE OF FUNERA | SIGNATURE OF FUNERAL SERVICE LICENSEE M00690 **Downer Funeral Home P.O.B. 186, Warrenton, VA 22186 | | | | | | | | | | | | |
| Ca aft | | 23. PART i. Enter the di shock, or h | | omplications the | | | not ente | r the mo | de of dying, aud | ch as car | diac Dr rei | spiratory ar | rest, | Approxi | imate Between |
| P O E | | IMMEDIATE CAUSE (Fir | nei | Onset e | | | | | | | | end Deeth | | | |
| | | disease or condition resulting in deeth) | \rightarrow | Cai | te n | ujolar | dia | l ci | youther | M | | | | 5 d | ays |
| 4 5 2 3 | | | a. Coute supcondition a. Coute supcondial infanction DUE TO (OR AS A CONSEQUENCE OF): b. complete heart block | | | | | | | | 50 | lays | | | |
| 13. | CERTIFICATION | Sequentially list conditi | ibiis, | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | ago | | | | |
| BOX ficate be e physician ne prior to | CAT | If eny, leading to imme- cause. Enter UNDERLY | ING | c. | | | | | | | | | | | |
| O. B(certificat nding phy Hygiene p | Ė | CAUSE (Diseese pr inju | | DUE TO | OR AS A | CONSEQUENCE | OF): | | | | | | | | |
| P.O. death certi | Ë | resulting in deeth) LAS | " L. | | | | | | | | | | | | |
| (a # 2 3 | اب | PART II. Other significa | ant condition | ns contributing to death but not resulting in the underlying couse given in | | | | | | | | 241 | . WERE AUTOPSY | | |
| ₩ ₩ 8 € L | S | | | | | | | | | PERFORMED? | | | 1 | AVAILABLE PRIC COMPLETION O OF DEATH? | |
| RECORI v requires that been signed by t. of Health an | MEDICA | | | | | | | | | · · · | | | 1 YES 2 | NO | |
| 3 d to 60 | Ä | | | | | Saper | | | | | | | | | |
| VITAL SIAN: The lar rifficate has ne State Oep or Item 23 | SICIAN: | 25. WAS CASE REFERRED T EXAMINER? | O MEDICAL | HOŞPITAL: | | | OTHE | | LACE OF DEATH (C | heck only o | ne) | | | | |
| | ı∠S | 1 YES 2 NO | | 1 Inpatient 2 | <u>.</u> | | | rsing Hon | ne 5 - Residence | _ | | W INJURY OC | OURER | | |
| IN OF NG PHYSI After this co eath with 1 marked, | ЬΗΥ | 1 Natural 5 | Pending | | Day, Year) | 200. 1 | NJURY M | WC | JURY AT ORK? YES 2 NO | 280. DE | SCHIBE HO | W INJURY OC | COHED | | |
| | BY | 2 Pulate | Investigation | 28e. PLACE | OF INJURY | — At home, farm | , street, fac | | | 281, LO | CATION (Stre | et and Numbe | r or Rural | Route Number, | |
| DIVISION OR ATTENDING OIRECTOR: After nours after death item 28 is ma | | 4 Homicide | Could not be determined | building | , etc. (Specif | fy) | | - | | City | or Town, St | ate) | | | |
| DIVISION OR ATTENDING ORECTOR: After hours after death | COMPLETED | 29a. CERTIFIER 1 CERT | TIFYING PHYSI | CIAN: To the best of | of my knowle | dge, death occu | rred at the | time, date | and place, and du | e to the co | use(a) and i | manner as str | nted. | | |
| HOSPITAL FUNERAL Within 72 | OME | ana) | | | | | | | death occured at the | | | | | a) and manner a | in stated. |
| HOS FUN Withi | | 29b. SIGNATURE AND TITLE | E OF CERTIFIER | 3, | | | | | 29c. LICENSE NU | IMBER | | 29d, DA | TE SIGNEI | D (Month, Day, Ye | er) |
| C THE HOSPITAL TO THE FUNERAL (be filed within 72 h |) BE | DA Fruche | nalu | No. | | | | | D374 | 124 | | • | 11/19 | 190 | |
| | 2 | 30. NAME AND ADDRESS O | F PERSON WH | | | | | 110.55 | | | MD | 20755 | EOO | · | |
| 9 | | DAVID H. BUI | | | | | KMX | HOSP | , FT. ME | SADE, | שמ | 20755 | -58U | <u> </u> | |
| | | NOV 28 | | 32. REGISTA Julia Da | | TURE -Pandelle | | | | | | | | | |



BALTIMORE, MARYLAND 21203-3146

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| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2- nours after death. Page 6 may be retained by the hospital or attending physician. | 70 THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

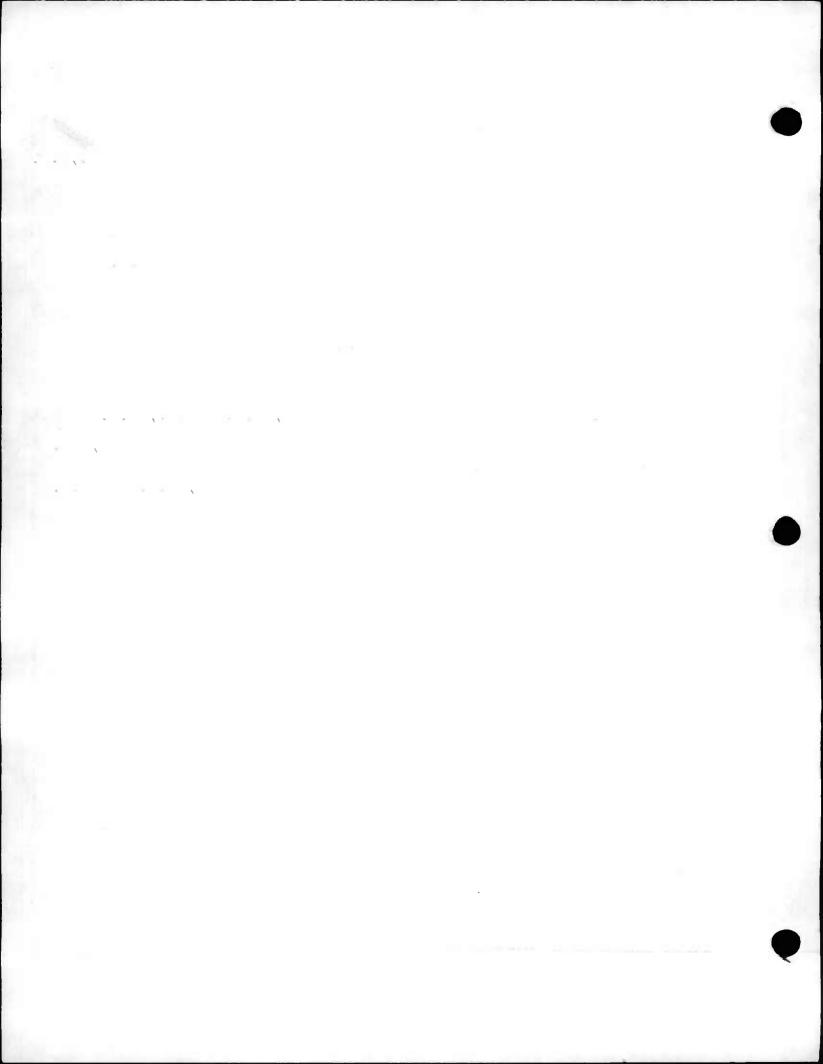
FRANK PERETTI, MD

Julia Davidson-Randall

| I. DECECENT 3 NAME (F) | rst, Middle, Last) An | sia | N. | D. | ial | | 2. DATE OF DEATH MONTH 11-20-9 | o. 90 | VEAD | 3. TIME DF OEATH 6:00AM |
|---|---|---|--|-----------------------|--|--|--|---|----------------------------|--|
| 4. SOCIAL SECURITY NU 578-62-9 | 257 | 5. SEX 1 M 2 K F | 6. AGE (In yrs. le | est birthday) YRS. | IF UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) 2/19/6 | | Country | Nash., D. C |
| 5713 Jame | stown I | | | | | N OR LOCATION OF O | EATH | | ce G | eorges Co. |
| Md. | 10b. COUNT Prin | v .ce Geoi | rge | 1 1 1 1 1 1 | y town or Lo | | A. 1769 | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 5713 Jar | | | | | 101. ZIP COOE 20782 | | | S.Z | HAT COUNTRY? | |
| 11. MARITAL STATUS 1 | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Store Manager 18b. KIND DF BUSINESS/INDUSTRY 18b. KIND DF BUSINESS/INDUSTRY 18b. KIND DF BUSINESS/INDUSTRY 18c. DECEDENT'S USUAL OCCUPATION (Give kind of working life. Do NOT use retired.) Store Manager | | | | | | | | ick | | |
| 17. FATHER'S NAME (First, Middle, Last) William H. Dial 18. MOTHER'S NAME (First, Middle, Melden Surname) Ethel Ferguson | | | | | | | | | | |
| William | H. Di | | | 4325 | Iowa | Avenue, | | Vash. | , D. | C. 20011 |
| 20s. METHOD OF DISPOS 1/O Buriel 2 O Creme 4 O Donation 5 Ott | er (Specify) | | other ; | nlecel | | cometery, cremetory or OVE Ceme | etery Je | ocation - o | | |
| 21. SIGNATURE OF FUNE Will: | | Ables | li. | | 22. NAME Ha. 62 | AND ADDRESS OF FA | ers Funda | eral : | Home | D.C. |
| 23. PART I. Enter the shock, or IMMEDIATE CAUSE (I disease or condition resulting in death) | heart fallure. | Strang | use on each lin | 18. | not enter the | | | | | Approximete interval Betwee Onset and Dest |
| Sequentially list cond if any, leading to imm cause. Enter UNDERI CAUSE (Disease or in | nediats LYING njury | b | O (OR AS A CONSI | EDUENCE O | F): | | | | | |
| that initiated events resulting in death) L | | | | | | | Pert I 24- Mac | IN AUTOPSY | 24b. | WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| that initiated events | cent condition | es contributing to | o death but not | resulting | in the underly | ing cause given in | PERF. | ORMED? | | COMPLETION OF CAUSE OF DEATH? XXX YES 2 NO |
| that initiated events resulting in death) L | | HOSPITAL: | □ ER/Outpetlent | | 26 | PLACE OF DEATH (Common STEPRESIDENCE | PERF- 1 X YES | | | COMPLETION OF CAUSE OF DEATH? |
| PART II. Other aigniff 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 [2 Accident | | HOSPITAL: 1 Inpetient 2 28a. DATE 0 11-2(| ER/Outpetlent | 3 □ DOA 28b. TIM 3:3 | 26 OTHER: 4 Nursing H IE OF 28c. UAM 1 | PLACE OF DEATH (C) ome \$100 Residence INJURY AT WORK? YES 2.300 NO | neck only one) 6 Other (Specify) 28d. DESCRIBE HOV | 2 I ND | cureo gled | COMPLETION OF CAUSE OF DEATH? XCX) YES 2 NO |
| that initiated events resulting in death) L/ PART II. Other aigniff 25. WAS CASE REFERRET EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 2 Accident 3 Suicide 6 4 Momicide | Pending Investigation Could not be determined | HOSPITAL: 1 Inpetient 2 28a. DATE 0 Month., 1 -20 28a. PLACE building | ER/Outpetient FINJURY Pay, 16gr) POFINJURY — At P I, etc. (Specify) | 3 DOA 29b. TIM 3:3 | 26 OTHER: 4 Nursing h BE OF URY 1 [etreet, factory, o | PLACE OF DEATH (Come Residence INJURY AT WORK? YES 2 X NO INTO THE PROPERTY OF THE PROPERTY O | eck only one) 6 Other (Specify) 28d. DESCRIBE HOW SUBJECT 28f. LOCATION (Street 5713 James | 2 ND VINJURY OCC STRANG A and Number Tel Stown | gled or Rural R | COMPLETION OF CAUSE OF DEATH? XXX YES 2 NO Dute Number, 1, Hyattsvi |
| that initiated events resulting in death) Li PART II. Other aigniff 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Accident 3 Suicide 6 (Accident) 29a. CERTIFIER 1 C C(Check only 1 C C) | Pending investigation Could not be determined | HOSPITAL: 1 Inpetian: 2 28a. DATE 0 1 1-2(28a. PLACE building | ER/Outpetient F INJURY Day, (Sept) OF INJURY — At 1 I, etc. (Specify) If my knowledge, (| 3 DOA 29b. TIM 3 3 | OTHER: 4 Nursing E OF URY OAM 1 [etreet, factory, o | PLACE OF DEATH (C) ome ***Presidence INJURY AT WORK? TYES 2 ****NO INTO: HOME ### HOME ### Broce, and du | 12 Aves 1 Other (Specify) 28d. DESCRIBE HOV Subject 28f. LOCATION (Street 7 13 James 7 13 James 7 10 Ce Geo | vinjury occ strand or and Number lestown | cureo gled or Rural R ROad | COMPLETION OF CAUSE OF DEATH? XXX YES 2 NO Dute Number, 1, Hyattsvi |

111 Penn Street, Baltimore, MD 21201

DHMH-16 Rev 1/89



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| BALTIMORE, MARYLAND 21203-3146 | we requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | s been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Playing and Mental Hygiene prior to burial, cremation, or removal. | 3 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| BALTIN | ours after death. Page | s been signed by the attending physician and completely filled in by the funeral d thealth and Mental Hygiene prior to burial, cremation, or removal. | medical examine |
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| Œ | W F | pt. | 63 |

1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH DAY 3. TIME OF DEATH YEAR EDWIN DASHIELL Rudolph 0200 03 1990 Dec. 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 6. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN. XX M 2 F 93 YRS. 212-20-8802 U.S.A. (MD) FEB 10 1897 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF GEATH Tender Love Inc. Cambridge Dorchester RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10e. STATE MD. Dor. Cambridge XX YES 2 NO 10a. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 604 Locust St. 21613 USA 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? ★ YES 2 NO IF YES, GIVE WAR OR DATES 11. MARITAL STATUS 13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yee or No—if yee, specify Cuben, Mexican, Puerto Rican, etc.)

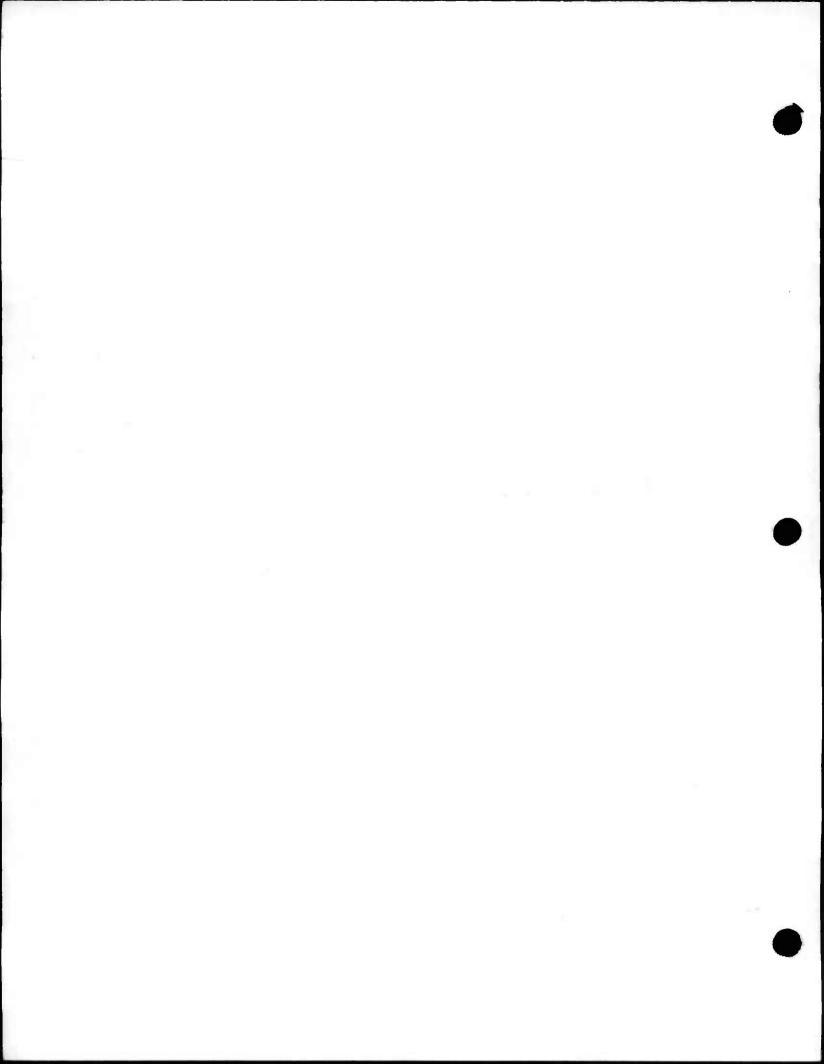
1 □ YES XIXNO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Merried 2 Merried Specify: white **X** ₩ Widowed 4 □ Divorced WW I 15. DECEDENT'S EDUCATION ecify only highest grade complete 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 18b. KINO OF BUSINESS/INDUSTRY (Spe Elementary/Secondary (0-12) College (1-4 or 5+) mariner-pilot 6 shipping, state of MD 18. MOTHER'S NAME (First, Middle, Maiden Surname) 17. FATHER'S NAME (First, Middle, Last) William F. Dashiell Mary Navy 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy McKnett 936 Galen Drive, State College PA.16803 20a. METHOD OF DISPOSITION 20b. PLACE OF OISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State 20a. METHOD OF DISPOSITION

XX Burlel 2 Cremetion 3 Removal from State
4 Donation 5 Other (Specify) Green Lawn Cemetery Cambridge Md. 22. NAME AND ACCRESS OF FACILITY Thomas Funeral Home 21. SIGNATURE OF BUNERAL SERVICE LICENSEE Thomas Sunits 700 Locust St. Cambridge Md.21613 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart fallure. List only one cause on each line. intarvai Batwean IMMEDIATE CAUSE (Final Onsat and Death disease or condition . CONGESTIVE HEART FAILURE raaulting in death) DUE TO (OR AS A CONSEQUENCE OF): PROSTATE STAGE D-2 21 MINITUS · ADENO CARCINO MA Sequentially list conditions. DUE TO (OR AS A CONSEQUENCE OF): If any, leading to immediate cause. Enter UNDERLYING CAUSE (Dianase or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated avents reaulting in death) LAST PART ii. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? PERFORMED? LYMPOCYTIC LEUKENUA 1 TYES 2 NO 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) HOSPITAL: OTHER:
42 Nursing Home 5 Residence 6 Other (Specify) 1 TES 2 NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. MANNER OF OEATH 28e. OATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCUREO INJURY 1 Netural 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) a Could not be 4 Homicide 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, date end place, end due to the cause(e) end menner as stated. 2 MEDICAL EXAMINER: On the beele of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end menner ee stated. 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) 2-16609 uclou Laterous 1/2 90 3 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOSKEWICZ MICHAER 31. DATE FILED (MONTE PROV. Mar)4 32. REGISTARES, SIGNATURE '90 Randell.

TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1 4 be.

DIVISION OF VITAL RECORDS

DR ATTENDING PHYSICIAN: The law



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Zernours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burla-transit permit. Pages 1, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | HEGISTHAN | | - CL | . 1 2 1 11 1 | CATE | T DEA | *** | REG. | NU. | | |
|---------------|---|---------------------|------------------------|----------------------------|------------------------------|-----------------|-------------|--------------------------------------|--------------------------|---------------|---|
| i. | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF DEAT | H | YEAR | 3. TIME OF DEATH |
| 1 | ELMA H. DONG | NAT A NE | | | | | | MONTH | Z.EE D. H | | |
| | 4. SOCIAL SECURITY NUMBER | | | | | | | Nov. 30 | | | 7:55 P. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last | | IF UNDER 1 YEA | | MIN. | 7. DATE OF BIRTH (Month, Day, Yea | | 6. BIRTH | PLACE (State or Foreign |
| | 387-16-4528 | 1 M 2 XF | 69 | YRS. | MONTHS DAT | 8 HOURS | MIN. | Dec. 24. | | | sconsin |
| ļ | 9a, FACILITY NAME (If not institution, give st | met and number) | | | 9b. CITY, TOW | N OR LOCATI | ON OF DE | | | JNTY OF DI | |
| ~ | | and these | | | 30. OH 1, 101 | N ON LOCALI | ON OF DE | EATH | st. 001 | JATT OF DE | -AIII |
| 6 1 | Anne Arundel M | edical | Center | | An | napo | lis | | A | nne | Arundel |
| 5 1 | | | W 12.11 U 12.1 | | 117 | | | | | | |
| DIRECTOR | 10e. STATE 10b. COUNTY | | | 10c, CITY | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY |
| # I | 36 m m 3 m m 3 M m m | A | - 1 | A | | | | | | | LIMITS? |
| <u>ا ۱</u> | | e Arund | ет | A | rnold | | | | | | 1 YES 2 NO |
| ₹ | 10e. STREET AND NUMBER | | | | - 1 | 101. ZIP COD | E | | 10g. Cl | TIZEN OF W | VHAT COUNTRY? |
| FUNERAL | 412 Manor Road | A . | | | | 210 | 012 | | 1 1 | U.S. | A |
| ΞI | 11. MARITAL STATUS | | IT EVER IN U.S. ARI | HED | 42 148.0 | | | NIC ORIGIN? (Specif | | _ | — American Indien, |
| Z | 1 Never Married 2 Merried | | YES 2 N | | | | | in, Puerto Rican, etc | | Black | k, White, etc. |
| B | 3 X Widowed 4 Olvorced | IF YES, GIVE Y | MAR OR DATES | | 1 🗆 | ES 2 NO | Specifi | y: | | Whi | fy: |
| | 3 ES WILLOWS 4 CHOICES | | | | | | | | | Whi | te |
| | 15. DECEDENT'S EDUC | | | | USUAL OCCUP | | | 166. KIND O | BUSINESS/IN | IDUSTRY | |
| E (| (Specify only highest grade | | - Illia | ve kind of w Do NOT use | ork done during retired.) | most of world | ng | | | | |
| ا ت | Elementary/Secondary (0-12) | College (1-4 or 5 | | | | | | | | | |
| 물비 | 12 | | | oord | inato | r | | Tou | r Gui | des | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | 100 | | 18. MOT | HER'S NA | ME (First, Middle, M | iden Sumame) | | |
| | Chamles Cuemi | | | | | M. | | Dools | | | |
| B | Charles Suomi | | | | | _ | | Beck | | | |
| ٥ | 19e. INFORMANT'S NAME (Type/Print) | | 196 | MAILING | ADDRESS (Str | et end Numbe | r or Rural | Route Number, City of | Town, State, 2 | (ip Code) | |
| ا ۴ | Thomas Donovan | | | 472 | Manor | Road | A . F | rnold. | MD 2 | 1012 | |
| | 20e. METHOD OF DISPOSITION | | | | ITION (Name o | | | | LOCATION - | | nun State |
| | 1 S Buriel 2 ☐ Cremetion 3 ☐ Reme | oval from State | other pla | ice) | | - | | | | | |
| 1 | 4 Donatjon & Other (Specify) | | Arlin | ton | | | | netery | Arli | ngto | n, VA |
| - 1 | 21. SIGNATURE OF FUNERAL BEHVICE EN | ENSEE / | |) | 22. NAM | E AND ADDRE | SS OF FA | CILITY | - | | 03.403 |
| - 1 | 691-11. | // | - | / | Tay | lor i | une | ral Ch | apel | | 21401 |
| Į. | enamo - | an | S | | 147 | Glou | ices | ter St | Ann | apol | is.MD |
| | 23. PART i. Enter the diseases, or o | emplications the | toused the de | ath. Do n | | | | | | | Approximate |
| - 1 | shock, or haart failure. | List only ona ca | on each line | | | | | | All the second | | intervai Between |
| - 1 | IMMEDIATE CAUSE (Finel | | , | - | | , | | | | | Onset and Death |
| | disease or condition | PALEA | 90:49 | TWENNUNIA FOUENCE OF): | | | | | | | Zuns |
| H | resulting in death) | DUE TO | OR AS A CONSEC | OUENCE OF | 1: | | | | | | Zyrs |
| | | A 11 - | 116 -00 | | | 0 | - | Χ | | | 146 VAC |
| Z | Sequentially liet conditions, | b. CHRON | OR AS A CONSEC | TRUC | 7116 | PULN | ONA | RY DISE | 45E | | 48 yrs |
| 2 | if sny, leading to immediate | | | | | | | | | | |
| 4 | cause. Enter UNDERLYING | Car | ZCINON | 100 | PF 78 | 15 | Lui | 16 | | | 10 VRS |
| E | CAUSE (Disease or injury that initiated events | | OR AS A CONSEC | | | | | | | | 1-11- |
| E | reaulting in death) LAST | | | | | | | | | | |
| CERTIFICATION | | d | | | | | | | | | |
| | PART ii. Other significent condition | a contribution to | a death but ant a | andala. I | - 46 | | -1 1 | Deat or un | | | |
| MEDICAL | PART II. Othar significent condition | e contributing to | death but not r | esurung r | n ina under | ying ceuse | given in | | S AN AUTOPS' RFORMED? | 7 240 | . WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 5 | | | | | | | | | ES 2 NO | | COMPLETION OF CAUSE |
| | | | | | | | | ··· · | 20 2 110 | | OF DEATH? |
| Σ | | | | | | | | | | | 1 TYES 2 NO |
| ä | | | | | | | | | | | |
| ≤ | 25. WAS CASE REFERRED TO MEDICAL | | | | 2 | . PLACE OF | DEATH (C/ | heck only one) | | | |
| 8 1 | EXAMINER? | HOSPITAL: | | 61-27 | OTHER: | 988 U 98 | - 1-0- | | | | |
| \ <u>S</u> | 1 YES 2 NO | | ☐ ER/Outpatient 3 | | | Home 5 🗆 F | leeldence | 6 Other (Specify | | | |
| PHYSICIAN: N | 27. MANNER OF DEATH | 28e. DATE O | F INJURY Day, Ybar) | 26b. TIM! | E OF 28c | INJURY AT WORK? | | 28d. DESCRIBE | IOW INJURY O | CCURED | |
| | 1 Natural 5 Pending | | ,,, | | | YES 2 | □ NO | | | | |
| B | 2 D ALLE | 28e PLACE | OF INJURY — At ho | me farm s | street factory | office | | 26f. LOCATION (S | treat and Numi | ner or Presel | Doute Number |
| | 3 Suicide 8 Could not be 4 Homicide determined | building | , stc. (Specify) | 1110, 141111, 4 | ili eet, iactory, | Diffice | | City or Town, | State) | or or nurer : | noute Nambel, |
| El | 4 Nomicide determined | | | | | | | | | | |
| ا ت | 29e. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the heat o | d my knowledge de | oth popular | ed at the time | data and alno | a and da | a to the enverter of | 4 | tota d | |
| 를 I | cont only | | | | | | | | | | |
| COMPLETED | 2 MEDICAL EXAMINE | R: On the basis of | examination end/or | investigatio | n, in my opinie | on, death occi | ured at the | e tima, date end pla | e, end due to | the cause(| e) end manner ee stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIE | R | | | | 29c, LIC | CENSE NU | MRER | 29d. D | ATE SIGNED | (Month, Day, Year) |
| BE | 4- 1/6 BA | 111 | | | | | | | | | 3/90 |
| 5 | 1 grade | | - | | | 12 | 0/ | 064 | | 121. | 3/90 |
| F | 30. NAME AND ADDRESS OF PERSON WH | | | | | | | | | | |
| | James M. Cha: 31. DATE FILED (Mointh, Day, Year) DEC 04 1 | mhanlat | n M D | 2 | 60 D- | nino | 17.5 | Farm D. | A | h Lon | מוחופ מא |
| | 31. DATE FILED (Month, Day, Year) | TO DECISE | AD'S SIGNATURE | · | OB Y G | HTHE | ида | rain M | T. P. T. | HOTU | كالمالات اللالو |
| | 31. DATE FILED (MORRI, Day, 1981) | 32. HEWSTR | AN S SIGNATURE | 2.1. | 0_ | | | | | | |
| - 1 | DEC 04 19 | JYU GUNG | L Navidson- | Mouten | | | | | | | |
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filled in by the funeral director, page 5 should be detached for use as the

removal.

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cremation,

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signed by the attending physician a Health and Mental Hyglene prior to

been of h has by Dept. 1

certificate h

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After 1 death

DIRECTOR: J

and completely fi o burial, cremation

DIVISION OF VITAL RECORDS, P.O. BOX 13146, HOSPITAL OR ATTENDING PHYSICIAN:

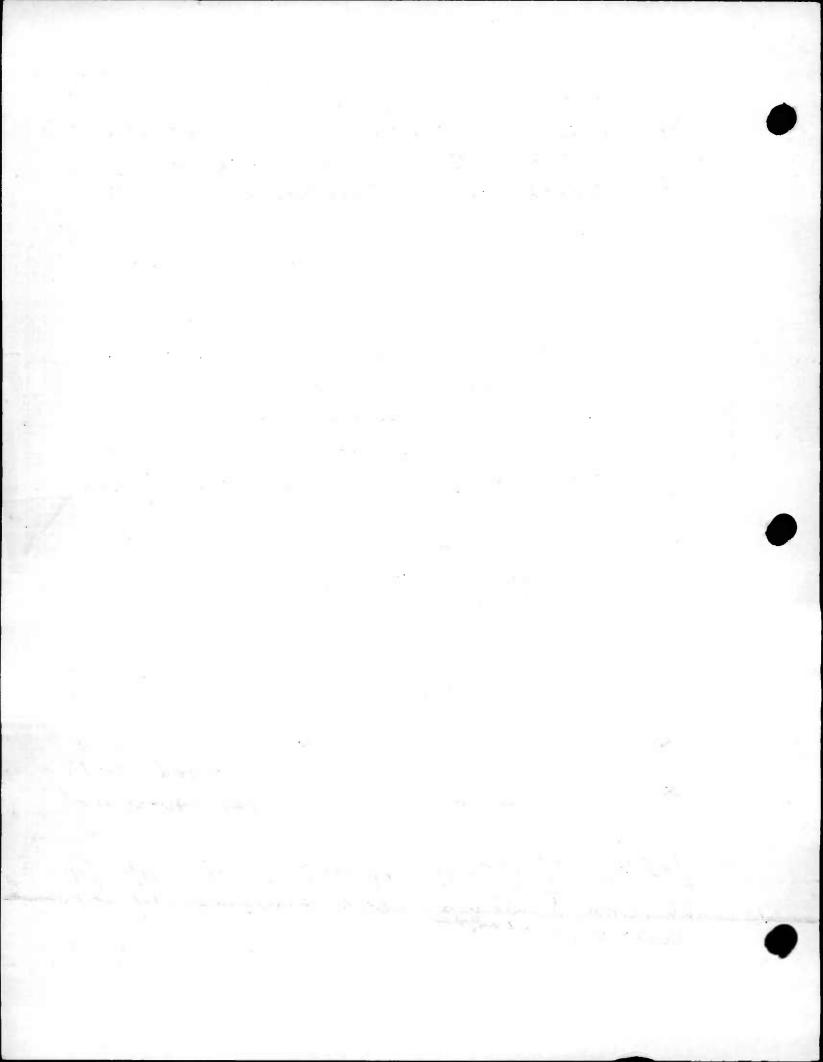
34353 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR Harold Burton DISTIN CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH HArold UNTOR 15+IN 25 4. SOCIAL SECURITY NUMBER 8. BIRTHPLACE (State or Foreign Country) 5. SEX 6. AGE (In yrs, last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year MONTHS DAYS HOURS MIN. 1 X M 2 - F 22 578-52-9444 NY Sc. COUNTY OF DEATH 9a, FACILITY NAME (If not institution, give street and number 9b. CITY, TOWN OR LOCATION OF DEATH 504 North DIRECTOR RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY 10d. INSIDE CITY LIMITS? Anne Arundel Tracy's Landing (Fairhaven) 1 YES 24 00 FUNERAL 10a. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? 10f. ZIP CODE 504 North Drive 20779 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 XNO 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuben, Maxican, Puerto Rican, atc.)

1 ☐ YES 2 🛣 NO Specify: 1 Never Married 2 Married IF YES, GIVE WAR OR DATES 1 YES 2 NO BY 3 K Widowed 4 Divorced white 0 15. OECEDENT'S EDUCATION (Specify only highest grade comple 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY COMPLET Elementary/Secondary (0-12) College (1-4 or 5+) Marble setter Construction-Masonry 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Milton Distin Ethe1 Burton BE 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert M. Distin 8377 Albacore Ct., Pasadena, MD 21122 e e 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State must 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria, VA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home, Owings, MD 20736 medical 23. PART I. Enter the diseases, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failura. List only one cause on each line. interval Between **Onset and Death IMMEDIATE CAUSE (Final** other traumatic event, the disease or condition DUE TO (OR AS A CONSEQUENCE OF): resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequantially list conditions, If any, leading to immediate cause. Enter UNDERLYING K '5 158A5-8 CAUSE (Disease or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in death) LAST 10 shows any injury, PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL PERFORMED AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 TYES 2 NO 1 YES 2 NO PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Item EXAMINER? OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 4 - Nurs me 5 Realdence & Other (Specify) 6 27. MANNER OF OEATH 28a. DATE OF INJURY 26c. INJURY AT WORK? 28b. TIME OF 28d, DESCRIBE HOW INJURY OCCURED marked, 1 Natural TANG 1 YES 2 NO BY Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office byliding, atc. (Sposity) 3 Suicide 28t. LOCATION (Street and Number of Rural Route Numb 28 is COMPLETED 6 Could not be 4 Homicide llem. 29a, CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated TO THE FUNERAL DID THE FUNERAL DID BE SIED WITHIN 72 ho 2 MEDICAL EXAMINER: On the basis of axe tion and/or investigation, in my opinion, death occured at the time, data and placa, and dua to the cause(a) and manner as stated. SIGNATURE AND TITLE OF CERTIFIE 29c. LICENSE NUMBER 29d. DATE SIONED (Month. Day, Year) BE WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, 2

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FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO 1. DECEDENT'S NAM 3. TIME OF DEATH 7 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE/OF BIRTH 6. BIRTHPLACE (State or Foreig 24, ug. 929 Virgini 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH DIRECTOR Arundel Medical Center Anne Annapolis Anne Arundel RESIDENCE OF DECEDENT 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Anne Arundel 1 YES 2 X NO Annapolis 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 1501 Duvall Road 21401 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-it yes, specify Cuben, Mexican, Puerto Rican, etc.) RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES 1 Never Merried 2 Married BY 1 YES 2 XNO Specify: 3 🔀 Widowed 4 🗌 Divorced COMPLETED 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working 15. DECEDENT'S EDUCATION ecity only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY (Spe (Give kind of work done life. Do NOT use retired.) Elementery/Secondary (0-12) College (1-4 or 5+) Rural Mail Carrier U.S. Postal Service 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Lee Hounshell BE Laura E. Oaks 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Ronald Dawson Duvall Road, Annapolis, MD 21401 20a. METHOD OF DISPOSITION
1 X Burlal 2 Cremation 3 Re 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, State ☐ Donation 5 ☐,Other (Specify) Hillcrest Cemetery Annapolis MD 21. SIGNAPURE OF FUNERAL SERVICE LICENSES 22. NAME AND ADDRESS OF FACILITY
Taylor Funeral Chapel 6 147 Gloucester St., Annapolis, MD unde 23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, Dr heert feliure. Liet only one cause on such line. Approximate Interval Between IMMEDIATE CAUSE (Final **Onset and Death** diseese or condition DUE TO JOR AS A CONSEQUENCE OFF resulting in death) artatie CERTIFICATION Sequentielly list conditions. DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING 0 CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF) that initiated events resulting in deeth) LAST Smoke PART ii. Other significant conditions contributing to death but not recuiting in the underlying ceuse given in Part i. PHYSICIAN: MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS WAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 HO 1 | YES 2 | NO 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 YES 2 NO nt 2 - ER/Outpetlant 3 - DOA 4 - Nursing Home 5 - Residence 6 - Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending BY 1 YES 2 NO 2 Accident Investigation 28e. PLACE OF INJURY — Al home, farm, street, factory, office building, atc. (Specify) 3 Suicide COMPLETED 6 Could not be determined 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated (Check only one) 2 MEDICAL EXAMINER: On the beals of axamination and/or investigation, in my opinion, death occured at the time, data and place, and due 29b. SIGNATURE AND TITLE OF CERTIFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 1271 499 2 mand IESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 30. NAME AND ADJ James M.D.

2525 Riva Road, Annapolis, MD 21401

31. DATE FILED (Month, Day, Year) -

Ruppel

32. REGISTRAR'S SIGNATURE

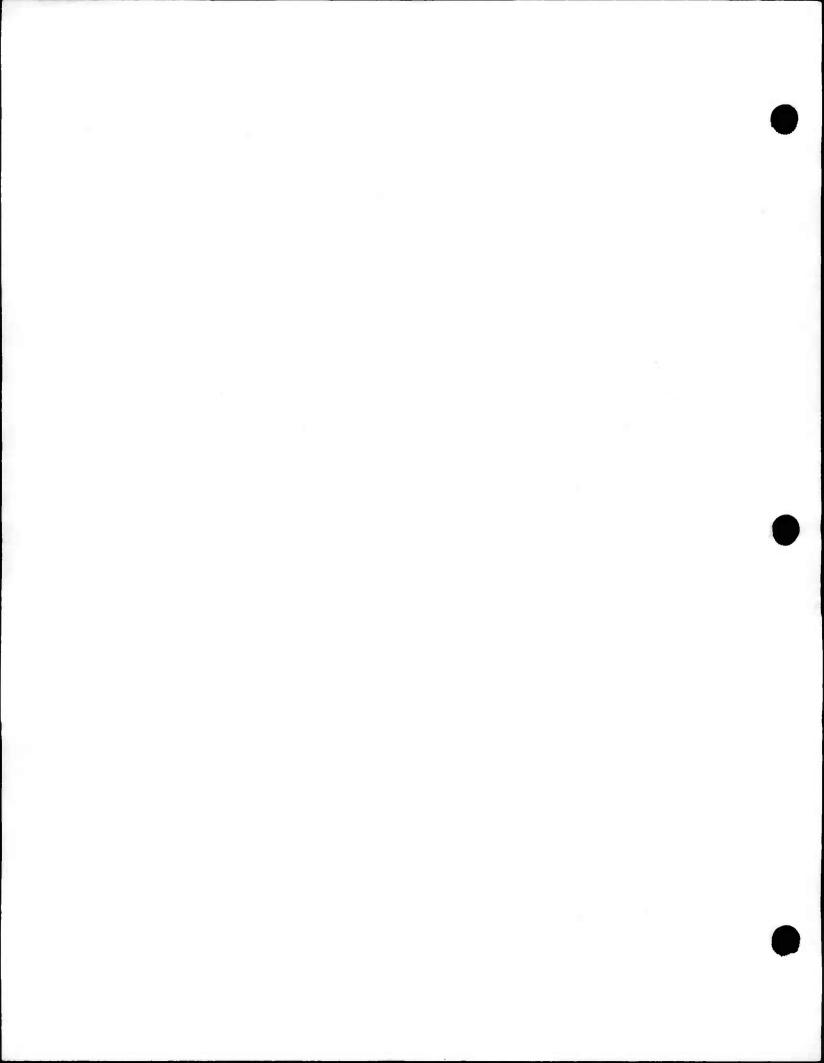
Ψ Alm 15 k z z mil 1 - FOR STATE REGISTRAR

| | | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND CERTIFICATE OF DEATH | MENTAL HYGIEN | ~ | 34355 | | | | | | | | | |
|--|---------------|--|---|-------------------------|--|--|--|--|--|--|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) ROY DENTON | 2. DATE OF DEATH MONTH 12 0 | 6 90° | 3. TIME OF DEATH 8:58 a.m. | | | | | | | | | |
| (A) | | 4. SOCIAL SECURITY NUMBER 348-42-5191 1 M 2 F 42 YRS. S SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. WONTHS DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 0 6 - 1 6 - 4 8 | Cou | ATHPLACE (State or Foreign intry) Pida | | | | | | | | | |
| | TOR | 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF E JOHNS HOPKINS HOSPITAL RESIDENCE OF DECEDENT 9c. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF E BALTIMORE CI | | 9c. COUNTY OF BALTIM | | | | | | | | | | |
| nit. Pages | DIRECTOR | MD Anne Arundel Odenton | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | | | | | | | |
| 46 physiclan. burial-transit permit. Pages | FUNERAL | 1355 Odenton Road 21113 | | USA | F WHAT COUNTRY? | | | | | | | | | |
| ding physic the burial | BY | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 1 Ves 2 NO If yes, specify Cuban, Maxic I Yes 2 NO Specify Cuban, Maxic I Yes 2 NO Specify Cuban, Maxic I Yes 2 NO Specify Cuban, Maxic I Yes 2 NO Specify Cuban, Maxic I Not Sp | can, Puarto Rican, atc.) | Ble | ACE — American Indien, ack, Whita, atc. | | | | | | | | | |
| AND 21203-3146 the hospital or attending physician. detached for use as the burial-tran | PLÉTED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) To have a control of the | 16b. KIND OF BU | | | | | | | | | | | |
| MARYLAND 21; retained by the hospital of 5 should be detached for another at once. | COM | 12 FADI ICALOI. 17. FATHER'S NAME (First, Middle, Lest) Population 16. MOTHER'S N. | AME (First, Middle, Maiden | | 3 | | | | | | | | | |
| MARY be retained le 5 should | TO BE | 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural | ny Eileen Yoakum Tel Route Number, City or Town, State, Zip Code) otter Road, Glen Burnie | | | | | | | | | | | |
| ALTIMORE, I Jeath. Page 6 may be funeral director, page xaminer must be- | 5 5 5 T | 20a. METHOD OF DISPOSITION 1. Burlel 2 Cremation 3 Ramoval from Stata 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) | 20c. LO | CATION — City or | Town, Stata | | | | | | | | | |
| m = 2 = 1 | 2 | Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD | | | | | | | | | | | | |
| 46, B. Addition of the control of th | | 23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, ahock, or heart failure. Liet only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| P.O. BOX 131. sath certificate be execute intending physician and or trat thygiene prior to burial., or other traumatic. | CERTIFICATION | | | | | | | | | | | | | |
| requires that the central spine of Health and Me shows any Injury | MEDICAL | PART II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in | Part I. 24e. WAS AN PERFOR | MED? | Ib. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | |
| 2 Se as | PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO THER: 1 YES 2 NO THER: 1 Wirsing Home 5 Residence | | | | | | | | | | | | |
| | ву РНУ | 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY AT WORK? 2 | 28d. DESCRIBE HOW IN | JURY OCCURED | | | | | | | | | | |
| DIVISION OR ATTENDING DIRECTOR: After hours after death | | 3 Suicide 8 Could not be datermined 28e. PLACE OF INJURY — At home, farm, street, factory, offica building, atc. (Specify) | 281. LOCATION (Street a City or Town, State) | nd Number or Rural | Route Number, | | | | | | | | | |
| DI OSPITAL OI UNERAL DI Ithin 72 hoi ANT: If Ite | COMPLET | 29a. CERTIFIER (Check only one) MEDICAL EXAMINER: On the best of my knowledge, death occurred at the time, data and placa, and dua one) MEDICAL EXAMINER: On the besia of axamination and/or investigation, in my opinion, death occurred at the | a to the cause(a) and man | ner as stated. | (a) and manner as stated. | | | | | | | | | |
| DIVISION C TO THE HOSPITAL OR ATTENDING PH TO THE FUNERAL DIRECTOR: After th be filed within 72 hours after death w IMPORTANT: If Item 28 is mark | TO BE | 296. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUR E98 (| MBER O C | 29d. DATE SIGNED | (Month, Day, Year) | | | | | | | | | |
| | | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E. CHAWN HATT JOHNS HOPKING | HOSPI | TAL B | ALTIMOREN | | | | | | | | | |
| | | 31. DATE FILED (Month, Day, Year) DEC 0 7 1990 Julia Duridon Mandale. | | | | | | | | | | | | |

34355

and the second

| | _ | _ | 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | |
|--|------------------|---------------|--|--|--|---------------------|--------------------------|--------------------------|------------------------------------|------------|---|-------------------|-----------------------------|--|
| • , | 1 | | 1. DECEDENT'S NAME (First, Middle, Last) MYRA | | | | EVA | | | MONT | OF DEATH | 27 19 | EAR 3. | TIME OF DEATH |
| (| P | | 4. SOCIAL SECURITY NUMBER 219-30-8713 | 1 🗆 M 2 💢 F | NGE (In yrs. last | t birthday) YRS. | IF UNDER 1 | | IF UNDER 24 HRS. | 7. DATE | OF BIRTH th, Day, Year) T. 23, 19 | A 8. | BIRTHPL Country) MARY | ACE (State or Foreign |
| 2, 3 sho | 4 | TOR | 9a. FACILITY NAME (If not institution, give s PENINSULA GENERAL RESIDENCE OF DECEDENT | | | | | ISBU | RY | EATH | | 9c. COUNTY WIC | OMIC | |
| Pages | Marine Ja | DIRECTOR | 10e. STATE 10b. COUNTY | r ICOMICO | | | , TOWN OR | | | | | | | d. INSIDE CITY |
| t permit. | | - 11 | 10e. STREET AND NUMBER | COMICO | | MA | KUELA | | RINGS | | - | 10g. CITIZE | | YES 2 NO |
| 5 ysician. rial-transi | | FUNERAL | MAIN STREET 11. MARITAL STATUS | 12. WAS DECEOENT EVE FORCES? 1 1 Y | | | 13. W | AS OECEN | 2 183 | NIC ORIGI | N? (Specify Yee | | SA RACE | American Indian, |
| 21203-3146 tal or attending physician. for use as the bunal-tran | | ED BY | 1 X Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR O | OR DATES | | 1 [| ☐ YES 2 | fy Cuban, Mexico NO Specif | y: | | | Specify: | WHITE |
| S 5 5 | | | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) 2 YEARS | (Gh | CEDENT'S I | ork done du retired.) | CUPATION iring most o | of working | 188 | . KIND OF BUS | | TRY | |
| AND 2: the hospital detached to | once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | ZIEARS | 1 1 | EACH | EK | 1 | 8. MOTHER'S NA | ME (First, | SCHO(| | | |
| <u> </u> | 70 | BE | | STATON | EVANS | | | | LILL | | (unk) | | OSLE | Ε |
| 2 2 | be notified | 2 | 19a. INFORMANT'S NAME (Type/Print) CAROLYN O' CONNER- | | 2 | 2681 | S.NEW | VARK | CT., A | | | | | 0010 |
| Page 6 may | must | 1 | 1 N Buriel 2 Cremetion 3 Remid | | 20b. PLACE Control of the place MARDE | ELA S | PRINC | of comete SS CE | ery, crematory or EMETERY | | | DELA S | | State GS, MD |
| ALT death. | examiner | | 21. SIGNATURE OF FUNERAL SERVICE LIC | llen | L | | 501 | ISNO | ADDRESS OF FA AY FUNE W HILL | RD, | SALISE | BURY, | | 2 180 1 |
| hin 24 mours af tely filled in by mation, or remo | the m | | 23. PART I. Enter the diseasea, or cahock, or haart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | clat only one gaugero | each line. | | | | | h aa car | diac or respi | ratory arrea | t, | Approximate interval Batween Onset and Death |
| X 1314 be executed clan and con or to burial, | 80 | ALION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR) | DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 2 da | |
| P.O. death certification attending intal Hygiel | ry, or other | CERTIFICATION | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| DS true | hows any injury. | EDICAL | PART II. Other aignificant condition | a contributing to deat | ontributing to death but not reaulting in the underlying cause given in Part | | | | | Part I. | Part I. 24a. WAS AN AUTOPSY PERFORMEO? | | | RE AUTOPSY FINDINGS IILABLE PRIDR TO MPLETION DF CAUSE OEATH? |
| AL RECOR | 23 shows | | | | | | | | | - | | | 1[| YES 2 NO |
| SICIAN: The lar certificate has | r item 23 s | 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 THO | HOSPITAL: | | | OTHER: | | E OF DEATH (Ch | | | | | |
| OF V PHYSICIAL this certifi with the | 9 3 | | 27. MANNER OF DEATH | 28e. DATE OF INJUI (Month, Day, Yea | RY | 28b. TIME | OF 2 | 8c. INJURY WORK | 5 Residenca Y AT | | CRIBE HOW IN | JURY OCCUR | ED | |
| | Tage 2 | | 1 Natural 5 Pending 2 Accident Investigation 3 Suicide | 28e. PLACE OF INJU | | 77000 | M | 1 TYES | 2 🗌 NO | **** | | | | |
| DIVISION DR ATTENDING DIRECTOR: Atter hours after death | 00 L | | 4 Homicide determined | building, etc. (8 | Specify) | | | | | City | ATION (Street as or Town, State) | | Rural Route | Number, |
| TO THE HOSPITAL D TO THE FUNERAL D be filed within 72 ho | ANT: If item 2 | T COM | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC ONE) 2 MEDICAL EXAMINE | CIAN: To the best of my kr R: On the basis of axamine | | | | | | | | | ause(s) an | d manner as stated. |
| TO THE H TO THE FI | PORT | | 296. SIGNATURE AND TITLE OF CERTIFIER | eles. (). | MO |) | | 25 | C. LICENSE NUM | ABER | 7 | | GNED (Mo | nth, Day, Year) |
| | ≥ 6 | | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF | | | | Sal | isbu | ru | M.D. | D 18- | 1 | |
| | V | 7 | 31. OATE FILED (Month, Dey, Year) NOV 3 0 '90 | 32. REGISTRAR'S S | IGNATURE | | 60 | Jen | .00 | 0 | , | D 100 | | |



| BALTIMORE, MARYLAND 21203-3146 | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few in after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burian hours after death with the State Dept, or Health and Mental Horinge notor in his in tremation or personal | item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| ORDS, P.O. BOX 13146, | OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the state of DRECTOR: After this certificate has been signed by the attending physician and completely filled in by the finduse star death with the State Debt of Hanth and Mental Husiner and remarking or removal. | s any injury, or other traumatic event, the mes |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | OR ATTENDING PHYSICIAN: The law requires DIRECTOR: After this certificate has been sign hours after death with the State Dent, of Hea | Item 28 is marked, or item 23 shows |

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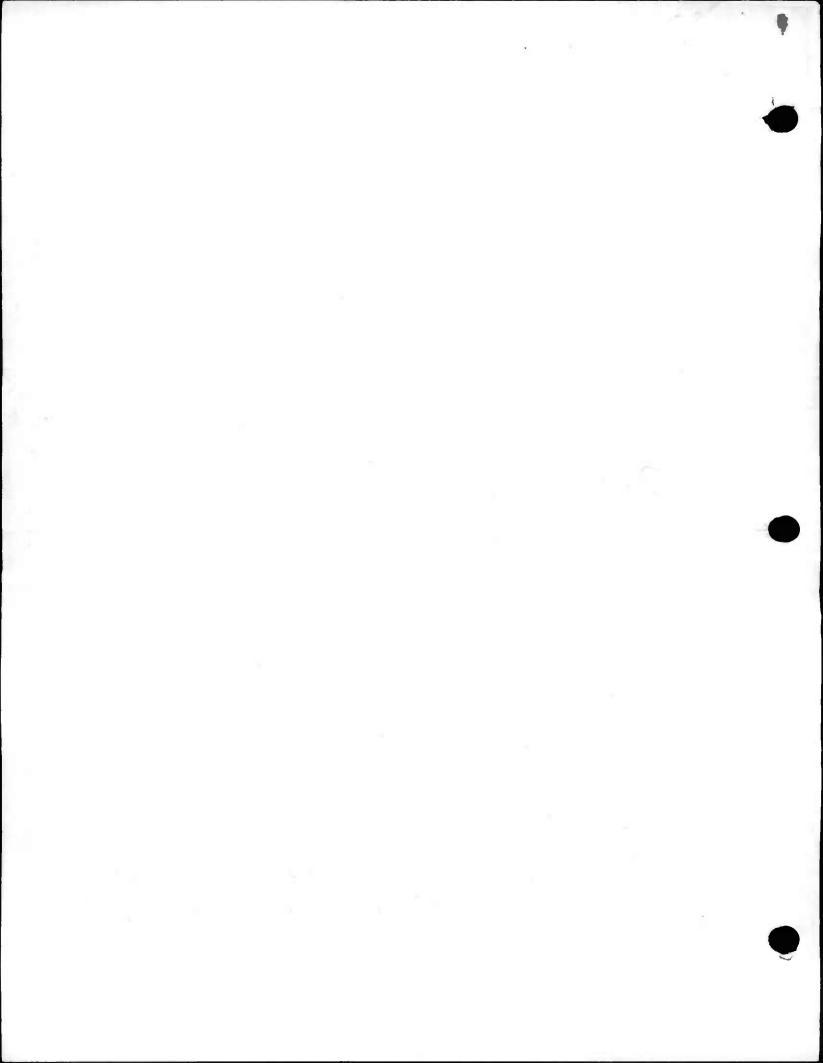
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1 - FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Katherine Etchinson 11 90 8:00 4. SOCIAL SECURITY NUMBER 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7. DATE OF BIRTH (Month, Day, Year, 8. BIRTHPLACE (State or Foreign 95 YRS. MONTHS DAYS HOURS 579-26-1319 1 🗌 M 2 💢 🕏 10/12/1895 Maryland 9e. FACILITY NAME (If not institution, give atreet end number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR SALISBURY NURSING HOME SALISBURY, MD. WICOMICO RESIDENCE OF DECEDENT 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Worcester Pocomoke 1X YES 2 NO FUNERAL 10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? Second Street 21851 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indien, Black, White, atc. 1 Never Merried 2 Merried If yes, specify Cuben, Mexicen, Puerto Ricen, etc.)

1 YES 2 NO Specify: IF YES, GIVE WAR OR DATES B 3 Wildowed 4 Divorced Specify: white COMPLETED 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comple Elementery/Secondary (0-12) College (1-4 or 5+) 11 Educator 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) A. Hartley Stevens Stella Adkins 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Rosemary S. Peters 1002 Beaglin Park Dr ,Salisbury, Md.21801 20a METHOO OF DISPOSITION
1 Burlel 2 Cremetion 3 F
4 Donetion 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — Cify or Town, State 3 - Removal from State Cem. Pitts Creek k Presbyterian Pocomoke, 21. SIGNATURE OF FUNERAL SERVICE LICENSEE Melson Funeral Home PO BOX 64, Pocomoke, 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, **Approximata** shock, or heart failure. List only one cause on each line. intarval Between IMMEDIATE CAUSE (Final **Onset and Death** disease or condition 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF) if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseasa or injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST conditions contributing to death but not resulting in the underlying cause given in Par) i. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 1 - YES 2-110 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) EXAMINER? HOSPITAL: OTHER: TO THE HOSPITAL OR ATTENDING PHYSICIAN.
TO THE FUNERAL DIRECTOR: After this certifica
be filed within 72 hours after death with the SI
IMPORTANT: If item 28 is marked, or If 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED Natural 2 Accident BY м 1 YES 2 NO 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) COMPLETED 8 Could not be 4 Homicide 29e. CERTIFIER
(Check only one)

2 MEDICAL EXAMINED: On the best of my knowledge, death occurred at the time, date end piece, and due to the ceuse(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIE BE 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year)



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mantal Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21203-3146

IMPORTANT. If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day,

| 1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | | | |
|--|---|--|---|-------------------------------|--------------|------------|--------------------------------|----------|--|-------------------|-----------|-------------------|--|
| 1. OECEOENT'S NAME (First | | Van5 | | | | | | | DATE OF I | DEATH DA | | YEAR 90 | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 215-05-89 | BEA | 5. SEX 1 M 2 1 F | 6. AGE (In y | rs. lest birthdey) YRS. | IF UNDER 1 1 | _ | IF UNDER 24 HRS. HOURS MIN, | 7 | DATE OF E (Month, Da | SIRTH y, Ybar) | | 8. BIRTI Count | HPLACE (State or Foreign ry) |
| 90. FACILITY NAME (If not in Manokin | | Nursing H | Iome | | | | LOCATION OF | DEATH | | | | inty of c | DEATH |
| RESIDENCE OF DEC | 10b. COUNT | v | | | | | | | | | | | |
| MD | | erset | | | Rt. 1 | - E | 30x 459 | fie - | ld Peyt | on F | ≀d.) | | 10d. INSIDE CITY LIMITS? 1 TYES 2 NO |
| 100. STREET AND NUMBER Rt. 1 - 1 | Box 45 | 9 | | | | 101. | 21817 | | | | 10g. CIT | | WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Merried 2 3 Widowed 4 Olvo | lt y | es, spec | NDENT OF HISP Lify Cuben, Mexi NO Spe | cen, Pu | RIGIN? (S | pecify Yes | or No— | 14. RAC | E — Americen Indien, k, White, atc. | | | | |
| 15. OEC (Specify only | EDENT'S EOU y highest grade | CATION completed) | 16 | e. DECEOENT'S | USUAL OCCI | UPATION | of working | | 16b. KIN | D OF BUS | SINESS/IN | DUSTRY | |
| Elementary/Secondary (0 Grade 5 | 1-12) | College (1-4 or 5+) | | (Give kind of life. Do NOT us | | | • | | Sh | oe S | tore | (Re | tail) |
| 17. FATHER'S NAME (First, M. | | | | | | | 16. MOTHER'S | | | | | | |
| Hezekia | | dshaw | | | | | | | nce | | | | |
| Vernon D. | | s | | | | | Number or Russ | | | | | o Coode) 2181 | 7 |
| 200. METHOD OF DISPOSITION 11-29-90 Burlet 2 Cremetion 3 Removal from State 4 Donetton 5 Other (Specify) | | | | | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | | | | | |
| . , , , , , | | 1.73 w | 4.60 | w | | 306 | W. Ma | in | St. | - Cr | isfi | eld. | |
| IMMEDIATE CAUSE (Fin | eert fellure. | complicationa thet List only one ceus | causad the | iline. | | a moda | a of dying, at | ich as | cerdiec | or respi | ratory ar | rest, | Approximate interval Between Onset end Daath |
| disease or condition resulting in death) | → | e | OR AS A CO | NSEQUENCE O | F): | nd i | n in | sh | | | | | |
| Sequentially list conditi | ons, | bDUE TO (| OR AS A CO | (h, | mic, | Mari | e duca | ~(| | | | | |
| if eny, leeding to immed cause. Enter UNDERLY! CAUSE (Disease or inju | NG | e | | 6 | mo brid | ر ا | leer | | | | | | |
| that initietad events resulting in death) LAS | | DUE TO (| OR AS A CO | NSEQUENCE O | D: - 5 | | | | | | | | |
| DART II Osh a stanting | - | a | | | | | 4 | | | | | | |
| PART II. Other significe | nt condition | e contributing to d | leath but i | not reaulting | in the unde | riying | cause given i | n Part | | PERFOR | | 24b | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | | | | | | | | | | | | 1 TYES 2 NO |
| 25. WAS CASE REFERRED TO | O MEDICAL | | | | | 26 Dt A | CE OF DEATH (C | Shoot o | 1 | | | | |
| EXAMINER? | | HOSPITAL: | ER/Outnatie | nt 3 🗆 DOA | OTHER: | | 5 Residence | | | | | | |
| 27. MANNER OF DEATH | _ | 26e. OATE OF I (Month, De | NJURY | 26b. TIM | E OF 28 | c. INJUF | RY AT | _ | | | NJURY OC | CURED | |
| | Pending investigation | 2000,1000 | | | | | S 2 NO | | | | | | |
| 3 Suicide 8 Could not be determined 25e. PLACE OF INJURY — At home, term, atreet, tectory, office building, etc. (Specify) 26e. PLACE OF INJURY — At home, term, atreet, tectory, office City or Town, State) 28t. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | Route Number, | | | | |
| | | CIAN: To the beat of n | | | | | | | | | | | n) and manner on eleted |
| | 2 MEDICAL EXAMINER: On the beele of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end manner ee stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | |
| | EJ | Cheu m | • | | | - [| | | 21 | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | | |

Princes

anne

32. REGISTRAR'S SIGNATURE
Likia Davidson-Andalle

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Present a filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

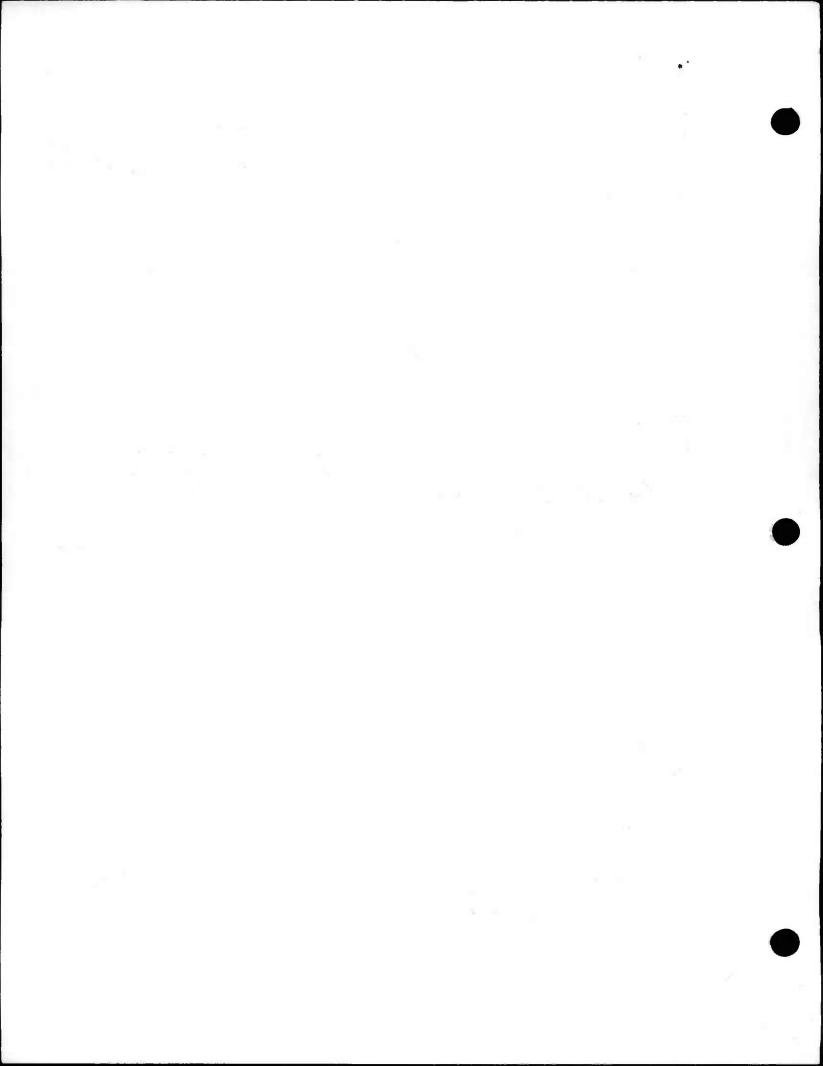
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)

DEC 0 4 '90

| | FOR 1 STATE | STATE OF M | ARYL | AND / I | DEPART | MENT OF | HEALTH | AND M | IFNT | AI HYGIEN | F | 20 | 04005 |
|--------|--|----------------------|----------------|----------------|--------------|----------------------|----------------------|-------------------------|-----------|-------------------------------------|---------------|--------------------|---|
| | REGISTRAR | | | CE | RTIFI | CATE OF | DEA | TH | 11001411 | REG. NO | | | |
| Ì | 1. DECEDENT'S NAME (First, Middle, Last) | Frankli | n | В. | For | tner | | | 2. DAT | E OF DEATH | AY / | YEAR | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | | | | | | | | | 2/2 | | 90 | 20:15 |
| | 206-12-0165 | 5. SEX 1 N 2 F | | in yrs. last i | | IF UNDER 1 YEAR | HOURS | MUM | (Mor | E OF BIRTH oth, Day, Year) | , | 8. BIRTH Countr | PLACE (State or Foreign |
| | 9e. FACILITY NAME (If not institution, give str | | | 52 | YRS. | cares. | | | | . 15, 1 | | Nor | th Carolina |
| | | | 9b. CITY, TOWN | | ON OF DEA | TH | | EATH | | | | | |
| 1 | 301 Hollingsworth | Manor | | | | Elktor | 1 | | | | Cec | il | |
| | 10e. STATE 10b. COUNTY | 10c. CITY, | TOWN OR LOCA | TION | | | | | | 10d. INSIDE CITY | | | |
| in the | Maryland Cecil | | | Elk | ton | | | | | | | LIMITS? | |
| Į | 10e. STREET AND NUMBER | | | | 10 | . ZIP COD | E | | | 10g, CIT | ZEN OF W | HAT COUNTRY? | |
| | 301 Hollingsworth | Manor | | | | | 2192 | 1 | | | | S.A. | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN | U.S. ARM | ED | 13. WAS DE | ENDENT (| OF HISPANIC | ORIGI | IN? (Specify Yes | | 14. RACE | - American Indian, |
| ı | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 | R OR DA | 2 ∐NO TES | | If yes, sp | ecify Cube | m, Mexican, Specify: | Puerto | Rican, atc.) | | Bleck | , White, etc. |
| i | | Korea | | | | | | | | | | Оросп | ^{y:} White |
| I | 15. DECEDENT'S EDUC: (Specify only highest grade of | ATION completed) | _ | (Glvn | kind of wo | SUAL OCCUPATI | ON Isl of working | na | 16 | b. KIND OF BUS | SINESS/INC | USTRY | |
| | Elementery/Secondary (0-12) | College (1-4 or 5+) | | ime. D | O NO! use | netired.) 1 Opera | | - | | Tamb - | 77 | | |
| H | 17. FATHER'S NAME (First, Middle, Last) | | | Dan | 1111 | - ober | | | | Lumber | | ustry | <u> </u> |
| I | | ov Fort | | | | | 18. MOTI | HER'S NAME | E (First. | Middle, Maiden | Surname) | | |
| ı | 19e. INFORMANT'S NAME (Type/Print) | oy Fort | ner | | | | | | | | Adam | - | |
| ı | Judy B. Fortner | | | | | DDRESS (Street | | | | nber, City or Town | n, State, Zip | Code) | |
| ŀ | 20e. METHOD OF DISPOSITION | | T | | | ollings | | | or | | kton | | 21921 |
| ı | 1 N Buriel 2 Cremetion 3 Removed | at from Stete | | OTHER DIRECT | 9) | ION (Name of cer | | natory or | | | CATION — | | |
| ŀ | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | , n | acki | er C | emetery | | | - | | | | e, VA |
| ı | | CA | / . | 1 | | Hic | K S H | ome I | ör | Funera | ls, 1 | P.A. | |
| I | Lalph | Ca. H | res | 60 | | F12 | ton | MD | 2.1 | n Stre | | | |
| ı | 23. PART I. Enter the diseases, or co shock, or heart failure. Li | mplications that | caused | the deat | h. Do no | t enter the mo | de of dyl | ng, such a | as car | diac or respi | retory arr | est, | Approximate |
| I | IMMEDIATE CAUSE (Final | at only one caus | e on eac | cn line. | | | | | | | | | Interval Between Onset and Death |
| ı | disease or condition resulting in death) | Pros | tu | te | Ca | ncer | | | | | | | 8 |
| | | DUE TO (C | R AS A | CONSEQUI | ENCE OF): | | | | | | | | o mo |
| | Sequentially list condition 5. | | | | | | | | | | | | |
| ı | Sequentially list conditions, if any, leading to immediate | DUE TO (C | R AS A C | CONSEQUE | ENCE OF): | | | | | | | | |
| ı | CAUSE (Disease or Injury | | | | | | | | | | | | |
| ı | that initiated events resulting in death) LAST | DUE TO (C | R AS A C | CONSEQUE | ENCE OF): | | | | | | | | |
| | d. | | | | | | | | | | | | |
| ł | PART II. Other significant conditions | contributing to d | eath but | t not res | ulting in | the underlying | Cause o | Iven in Pe | et I | 24e. WAS AN | HITOBEY | 100 | |
| ı | | | | | | | vanao g | | | PERFOR | | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| ı | | | | | | | | | - | 1 TES 2 | □ NO | | COMPLETION OF CAUSE OF DEATH? |
| ı | | | | | | | | | - | | | | 1 YES 2 NO |
| | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | | |
| | EXAMINER? | HOSPITAL: | | | | THER: | 11 | ATH (Check | | | | | |
| ı | 27. MANNER OF DEATH | 28e. DATE OF IN | | _ | Bb. TIME C | Nursing Hom | | | | | | | |
| | 1 Natural 5 Pending | (Month, Day, | | [* | INJUR | Y WO | RK? | | 8d. DES | SCRIBE HOW IN | JURY OCC | URED | |
| ŀ | 2 Accident Investigation 3 Suicide Could and by | 28e, PLACE OF | NJURY - | - At home | form etre | et, factory, office | ES 2 [| | | | | | |
| L | 4 Homicide a Could not be determined | building, at | c. (Specify | () | reriii, ette | et, factory, office | | 28 | City | ATION (Street er or Town, State) | nd Number (| or Rurel Ro | ute Number, |
| | 29e. CERTIFIER (Check only 000) | AN: To the best of m | y knowled | dge, death | occurred i | t the time, data | and place. | end due to | the ce | se(a) and men | ter as state | d | |
| L | 2 MEDICAL EXAMINER: | On the basic of exam | mination e | end/or Inve | stigation, | in my opinion, de | ath occure | d at the tim | e, date | and place, end | due to the | ceuse(e) | end manner as atated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | | 29c. LICE | NSE NUMBE | R | | 29d. DATE | SIGNED (| Month, Day, Year) |
| 1 | H. Sarker | ND | | | | | 7) / | 153 | 14 | 1 | 1 - | > /2 | 100 |

DHMH-16 Rev 1/69



FOR STATE REGISTRAR

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| | DSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within : | |
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31. DATE FILED (Month, Day, Year)

03'90

32. REGISTRAR'S SIGNATURE

Julia Davidson-Randall

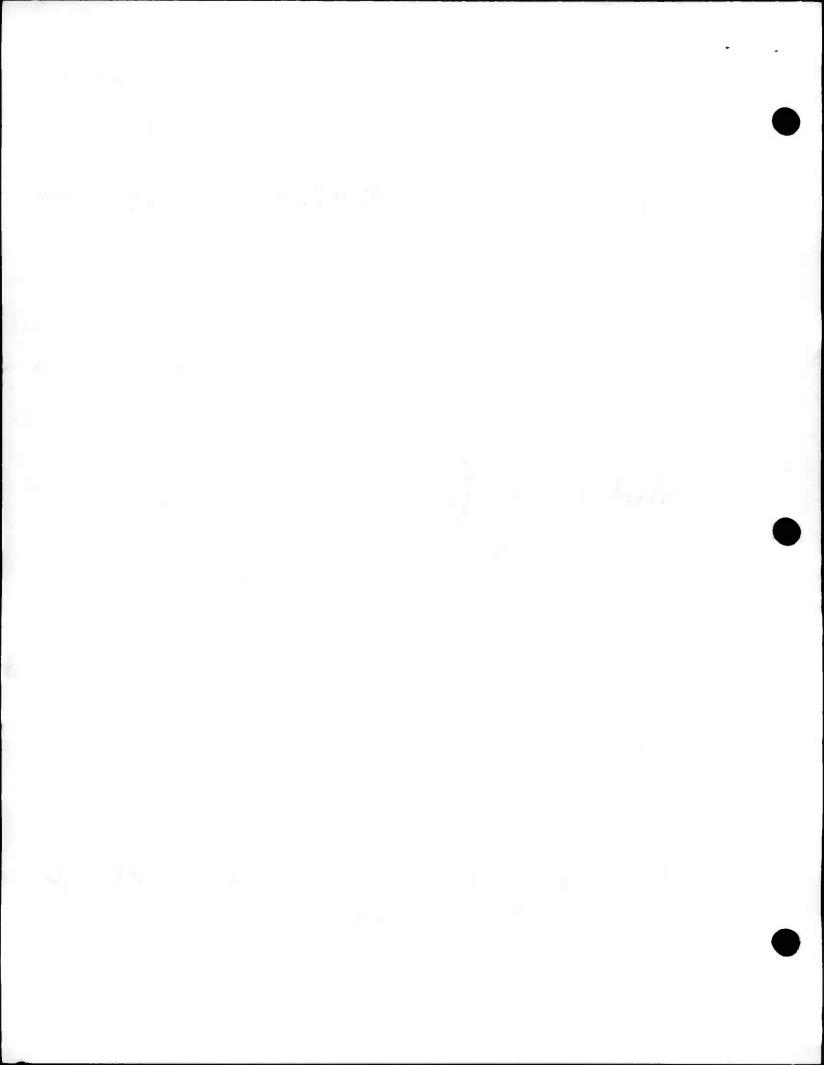
MENTIE DECEDENT'S NAME (First, Middle Last) CLYDE FENDER 2. DATE OF DEATH 3. TIME OF PEATH :L fU A 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS 7 DATE OF BIRTH 8. BIRTHPLACE (State or Foreign 578-14-5357 (Month, Day, Year) 7-24-1904 1 M 2 86 Virginia COUNTY OF DEATH, page 5 should be detached for use as the burlal-transit permit, Pages 1, 2, 3 should FACILITY NAME (If not institution, TOWN OR LOCATION OF DEATH RESIDENCE OF DECEDENT DIRECTOR 10b. COUNTY IOC. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Prince Georges Brandywine 1 YES 2 XNO FUNERAL 10e. STREET AND NUMBER 101 7IR CODE 10g. CITIZEN OF WHAT COUNTRY? 10901 Cedarville Road 20613 USA 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 11 MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No—If yes, specify Cuban, Mexican, Puarto Rican, atc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 1 Never Married 2 Married BY Specify: White 3 🛭 Widowed 4 🗌 Divorced 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) 넙 Elementary/Secondary (0-12) College (1-4 or 5+) Housewife COMPL Home 4 once. 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Malden Surname) at Freel Barton Cedella Ward notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 George O. Fender 10901 Cedarville Road, Brandywine, Md. 20613 å 20a. METHOD OF DISPOSITION
1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, Stata must 1 Burial 2 Cremation 4 Donation 5 Other (Specify) funeral director, Trinity Memorial Gardens Waldorf. Md. 21. Michard of Ruhenal Belower Jose examiner 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home filled in by the four, or removal. Р O. box 156. Waldorf, Md. 20604-0156 medical 23. PART I. Enter the diseases, or the deeth. Do not enter the mode of dying, such as cerdiec or reepiratory arrest, Approximata shock, or heart fallure. List only one cause Interval Between 6 IMMEDIATE CAUSE (Finei Onset and Death npletely filler cremation, the disease or condition_ DUE TO (OR AS A CONSEQUENCE OF): traumatic event, reculting in deeth) the attending physician and cor Mental Hygiene prior to burial, Condrovascolar Disease Asmosdorote Yas CERTIFICATION Sequentielly list conditione, If any, leeding to immediate DUE TO (OR AS A CONSEQUENCE OF): ceuse. Enter UNDERLYING CAUSE (Disease or injury other that initiated events resulting in deeth) LAST 6 Injury, PART II. Other significant conditions contributing to deeth but not reculting in the underlying ceuse given in Part I. MEDICAL 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO has been signed by a Dept. of Health and n 23 shows any in and a Colon. COMPLETION OF CAUSE 1 TYES 2 NO OF DEATH? GI. Adsorption Deficing 1 YES 2 NO PHYSICIAN: certificate har the State Du 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) **EXAMINER?** HOSPITAL:
1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Ho 1 YES 2 NO ma 5 🗆 Realdance 8 🗆 Other (Specify) 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY After this ce death with the marked, 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending Investigation M BY 1 YES 2 NO After t death 2 Accident OIRECTOR; Aff hours after des item 28 is n 26a. PLACE OF INJURY — At home, larm, street, factory, offica building, atc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 8 Could not be COMPLETED 1 CERTIFYING PHYSICIAN: To the best of my knowledge, desth occurred at the time, data and place, and due to the cause(a) and manner as stated. TO THE HOSPITAL OF THE FUNERAL OF THE MINING TO THE MINING TO THE IMPORTANT: If IN 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE Freddom DD1923 DO Nov-1990 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Brandyurne relasion M.D.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

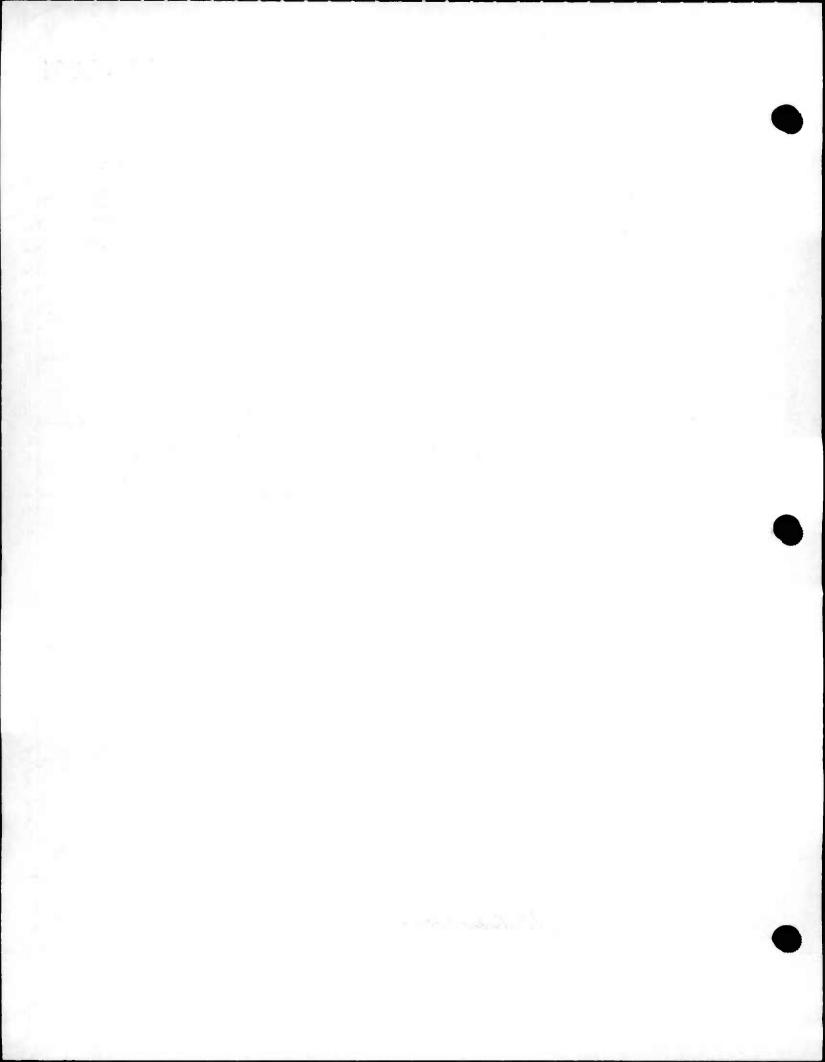
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| HALL OF RECORDS HALL OF RECORDS HALL OF RECORDS HALL OF RECORDS HALL OF RECORDS THOMAS KIMBEL THOMAS KIMB | _ | _ | 1 - STATE REGISTRAR | STATE OF MA | | | | OF HEALTH AND | MENTA | L HYGIENE REG. NO. | E | 70 | 04 | 201 |
|--|--|--------------|---|--------------------|---------------|----------------|----------------|--------------------------------|--------------|---------------------------------|-----------------|---------------------------------|----------------------|------------------------|
| THE STREET STATE OF THE STREET SANNE OF THE ST | (F | 5 | Louise | | | | ter | | MONTH | H DAY | | EAR | | |
| THE STATE OF THE STREET SHOW STREET 194 OF DEED STREET 194 OF DEED STREET 195 OF STREET 195 | , | 1 | | 1 🗌 M 2 🔏 F | | | | | (Month | h, Day, Year) | | Country) | | |
| THE THE AND NUMBER 19.49 DREW STREET 11. MARTINE BROWN 11. MARTINE BROWN 12. MARTINE BROWN 12. MARTINE BROWN 13. MARTINE BROWN 14. MARTINE BROWN 15. MARTINE BROWN 15. MARTINE BROWN 16. MARTINE BROWN 16. MARTINE BROWN 17. MARTINE BROWN 18. MARTINE BROWN 18. MARTINE BROWN 18. MARTINE BROWN 19. MARTINE | 2, 3 shoul | тоя | 1949 DREW STRE | , | | | | | EATH | | 9c. COUNTY | OF DEAT | н | |
| 19 19 19 19 19 19 19 19 | Pages 1. | DIREC | 10e. STATE 10b. COUNTY | | DEL | | | | | | | | LIMITS? | |
| THOUSE TO BE A SECURITY SOURCE AND A SECURIT | ust. | ERAL | 10e. STREET AND NUMBER | | <u> </u> | | | 10f. ZIP CODE | | | | OF WHAT | | |
| HALL OF RECORDS THOMAS KIMBEL THOM | 3146 ding physician the burial-tra | B | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT I | YES 2 | RMED MO | If y | S OECENDENT OF HISPAI | an, Puerto I | i? (Specify Yee Rican, etc.) | | RACE i Black, WI Specify: | hita, atc. | ndien, |
| THOMAS KIMBEL THOMAS | 2 a e | PLET | (Specify only highest grade c | completed) | (0 | Give kind of v | work done duri | UPATION ing most of working | 166. | | | TRY | | 3 |
| DOROTHY ROBINSON 19 49 DREW STREET ANNAPOLIS, MARYLAND 21401 20 DROTHY ROBINSON 20 DROWN STREET ANNAPOLIS, MARYLAND 21401 20 DROTHY ROBINSON 20 DROWN STREET ANNAPOLIS, MARYLAND 21401 20 DROTHY ROBINSON 20 DROTHY ROBINSON 21 DROWN STREET ANNAPOLIS, MARYLAND 21401 22 DROWN STREET ANNAPOLIS, MARYLAND 21401 23 DROWN STREET ANNAPOLIS, MARYLAND 21401 24 DROWN STREET ANNAPOLIS, MARYLAND 21401 25 DROWN STREET ANNAPOLIS, MARYLAND 21401 26 DROWN STREET ANNAPOLIS, MARYLAND 21401 26 DROWN STREET ANNAPOLIS, MARYLAND 21401 27 DROWN STREET ANNAPOLIS, MARYLAND 21401 28 DROWN STREET ANNAPOLIS, MARYLAND 21401 28 DROWN STREET ANNAPOLIS, MARYLAND 21401 29 DROWN STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH STREET ANNAPOLIS, MARYLAND 21401 20 DROTH ST | LAP by the be det | w II | THOMAS KIMBEL | | | | | KATE | ВОА | RDLEY | | | | |
| The state of the s | MA retai 5 sh | | DOROTHY ROBINS | | 20b. PLACE | 1949 | DREW | STREET A | | POLIS | , MAR | RYLA | | 1401 |
| The state of the s | | | 1 Buriel 2 Cremation 3 Remon 4 Donalion 5 Other (Specify) | | otner p | D/ECe) | VETE | RAN CEMET | | CR | OWNSV | TLL | Е, М | |
| PART II. Other significant conditions contributing to deeth but not resulting in the underlying ceuse given in Part I. 246. WAS AN AUTOPSY PERFORMEDY ANALABLE PRIOR TO COMMETTION OF CAUSE OF DEATHY 1 YES 2 NO 246. WAS AN AUTOPSY PERFORMEDY 1 YES 2 NO 246. WAS AN AUTOPSY PERFORMEDY 1 YES 2 NO 246. WAS AN AUTOPSY PERFORMEDY 247. WAS AN AUTOPSY PERFORMEDY 248. WAS AN AUTOPSY PERFORMEDY 249. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 246. WAS AN AUTOPSY PERFORMEDY 247. WAS AN AUTOPSY PERFORMEDY 248. WAS AN AUTOPSY PERFORMEDY 249. WAS AN AUTOPSY PERFORMEDY 249. WAS AN AUTOPSY PERFORMEDY 256. PLACE OF DEATH (INFORMEDY 257. WAS CASE REFERRED TO MEDICA | O. BOX 13146, no certificate be executed within anding physician and completely fillingine prior to burial, cremation, or other traumatic event, the | ERTIFICATION | Sequentielly list conditione, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | DUE TO (O | OR AS A CONSE | EQUENCE OF | Hear n: | | | flec or reepir | atory errest | , | Onset : | l Between and Deeth |
| EXAMINER? Line Lin | DS in the mid white wild the mid white | AL | Rementra | contributing to de | eeth but not | resulting | in the unde | rlying couse given in | Part I. | PERFORI | MED? | AVA | WLABLE PRIMPLETION (| IOR TO |
| EXAMINER? Line Lin | L HEC | | Cerchro vascul | lan Pise | ase | | | | | | | 1 |] YES 2 [| □ NO |
| A SONOW State of the period of | VIII/ ICIAN: TI entificate the State or iten | IYSICI | EXAMINER? 1 YES 2 NO | 1 inpatient 2 in E | 200-200-00 | | OTHER: | g Home 5/2 Residence | 6 🗆 Other | or (Specify) | | | | |
| Description of the design of t | JN OF After this death with | à | 1 Netural 5 Pending 2 Accident Investigation | (Month, Day, | (Year) | INJ | M · | WORK? 1 YES 2 NO | | | | | | |
| THE CHARGE OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID C. R-ARVES MD C. Frank And T. (140) | 28 after | ETE | 4 Homicide determined | building, etc | ic. (Specify) | | | | City | or Town, State) | | Purai Houte | Number, | |
| PREMISE OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAULD C. R-ARVES MD. El Franklan St. Augustus And 7 (40) | 크 크 | | (Check only one) 2 MEOICAL EXAMINER: | | | | | nion, death occured at the | time, date | | d due to the co | | | |
| DAULD C. BARNES MD SI Franklin St Aungsolis Md 21401 31. DATE FILED 1990 guilden des Aungsolis Md 21401 | TO THE De filed | | Durd C. Ba | | | FM 27) (Type | Drint) | 29c. LICENSE NUM | 169 | | ▶ /// | 36/9 | nth, Day, Ye | er) |
| | | | DAULD C. R.A | 4RNES | MD | modelle | Fra | intellar st | Aus | uapoles | Md | 2/4 | 101 | |



| DALLIMONE, MANILAIN | r death. Page 6 may be retained by the hos | e funeral director, page 5 should be detached | ii | examiner must be notified at once. |
|---------------------|--|---|--|--|
| | nours after | led in by t | , or remov | medica |
| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | TO THE HOSPITAL OR ATTENDIP | TO THE FUNERAL DIRECTOR: AI | be filed within 72 hours after de | IMPORTANT: If Item 28 is I |

| 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 824-32-8694 1 M 2X F 77 YRS. MONTHS DAYS HOURS 99. FACILITY NAME (If not institution, give street and number) RESIDENCE OF DECEDENT 100. STATE 100. COUNTY Maryland, Harford STATE OF MARYLAND / DEPARTMENT OF HEALTH CERTIFICATE OF DEAT CERTIFICATE OF DEAT 1. DECEDENT'S NAME (First, Middle, Last) 1. DECEDENT'S NAME (First, Middl | REG. NO. 2. DATE OF DEATH MONTH 30 24 HRS. MIN. 7. DATE OF BIRTH (Month, Day, Year) 4/14/13 9c. COUNTY OF DEATH ACC 10d. INSIDE CITY LIMITS? 1 R YES 2 NO | | | | | | | | | | |
|--|---|--|--|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) WHOTER 1 YEAR IF UNDER 2 90. FACILITY NAME (If not institution, give street and number) 90. FACILITY NAME (If not institution, give street and number) | 2. DATE OF DEATH MONTH 3. JEAR 3. TIME OF DEATH 3. JEAR 3. TIME OF DEATH 3. JEAR 3. TIME OF DEATH 3. JEAR 3. TIME OF DEATH 3. SENTTHPLACE (State or Foreign Country) 4/14/13 9c. COUNTY OF DEATH 4. CC 10d. INSIDE CITY LIMITS? 1 × JES 2 NO | | | | | | | | | | |
| 9e. FACILITY NAME (If not institution, give street and number) | N OF DEATH ACC Month, Day, Year) Country | | | | | | | | | | |
| / // | N OF DEATH 9c. COUNTY OF DEATH ACC Harford 10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO | | | | | | | | | | |
| III 10e. STATE 10b. COUNTY | 1 🔀 YES 2 🗌 NO | | | | | | | | | | |
| Maryland, Harford Aberdeen | | | | | | | | | | | |
| 106. STREET AND NUMBER 204 Darlington Avenue 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2X NO 14. Was December U.S. ARMED FORCES? 1 VES 2X NO 15. Was December U.S. ARMED FORCES? 1 VES 2X NO | 10g. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 13 Wildowed 4 Divorced 12. Was DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, specify Cuben, 1 YES 2 NO IF YES, GIVE WAR OR DATES 1 YES 2 NO | HISPANIC ORIGIN? (Specify Yea or No— Mexicen, Puerio Ricen, etc.) Specify: HISPANIC ORIGIN? (Specify Yea or No— Black, White, etc. Specify: | | | | | | | | | | |
| | White | | | | | | | | | | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondery (0-12) V N K 17. FATHER'S NAME (First, Middle, Last) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMARY 18. MOTHER | In home | | | | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHE | ER'S NAME (First, Middle, Meiden Surname) | | | | | | | | | | |
| W DNK | UNK | | | | | | | | | | |
| Donna Bigham Donna Bigham 395 South Drive | or Rural Route Number, City or Town, State, Zip Code) | | | | | | | | | | |
| 20e. METHOD OF DISPOSITION 1 | | | | | | | | | | | |
| 4 Donation 5 Other (Specify) R. A. Ferris & Company | . Inc. West Chester. PA | | | | | | | | | | |
| Aberdeen. | rgo Funeral Home, P.A. MD 21001-3399 | | | | | | | | | | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line. | g, such as cardiac or reapiretory arreat, Approximata | | | | | | | | | | |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) A Caudio Bull March 1 and | | | | | | | | | | | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | Lycuner Distance | | | | | | | | | | |
| PART If Other significant conditions contributing to death but not resulting in the underlying cause of | ven in Best I | | | | | | | | | | |
| The state of the s | PERFORMED? 1 YES 2 NO PERFORMED? AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | | | | | | | |
| Elizare lasorder : CHE | 1 YES 2 NO | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | ATH (Check only one) | | | | | | | | | | |
| 1 YES 2 NO 1 Inpatient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Reek 27. MANNER OF DEATH 28e. DATE OF INJURY 26b. TIME OF INJURY WORK? | dence 8 Other (Specify) 28d. DEŞCRIBE HOW INJURY OCCURED | | | | | | | | | | |
| 2 Accident Investigation M 1 YES 2 | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | | | | | | |
| 3 suicide 4 Homicide 8 Could not be determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred | and due to the cause(e) end manner ea stated. | | | | | | | | | | |
| 11 29h SIGNATING AND TITLE OF CONTIGION | SE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

LETT CATS S. D. L. L. L. M. D.

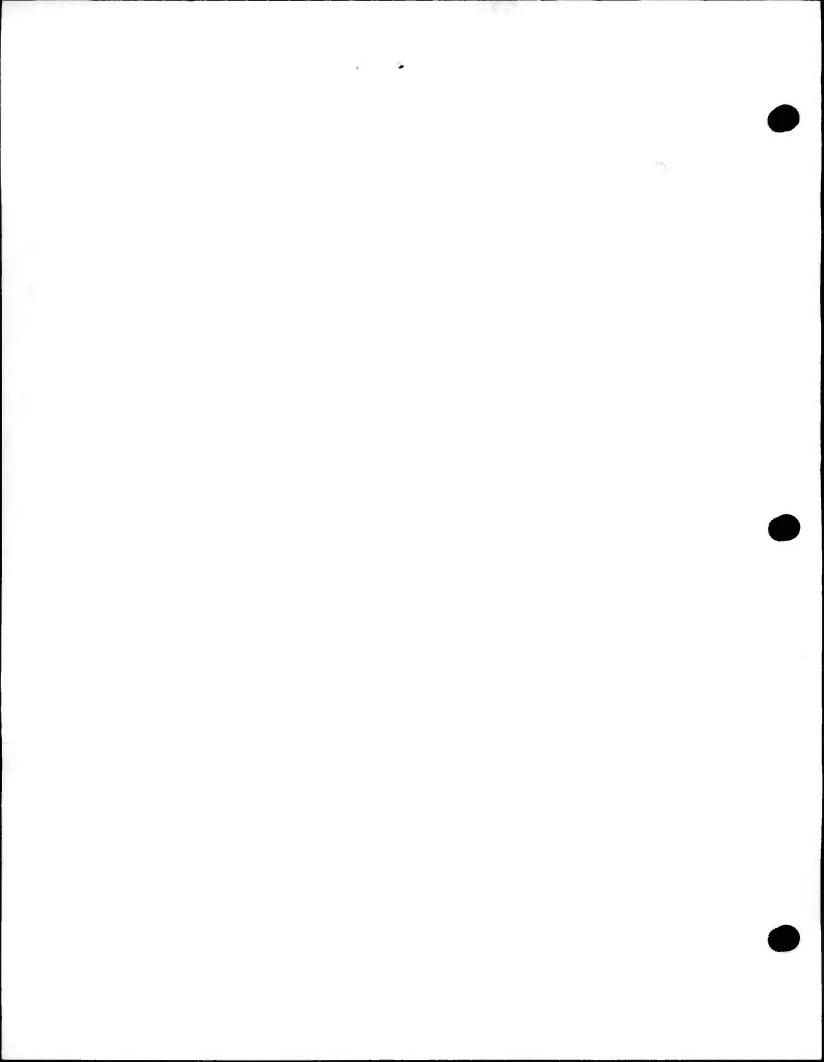
31. DATE FILED (Month, Day, Year)

BEC 0 4: 190

32. REGISTRAR'S SIGNATURE

BEC 0 4: 190

Gain Davidson—Randalle



| 9 | U | J | 13 | 3 | 6 | 3 |
|---|---|---|----|---|---|---|
| | | | | | | |

| 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | MENT OF H | EALTH AND M | IENTAL HYGIEN | | 90 3436 |
|--|---|--|------------------------------------|------------------------------|---|--------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) LESTE | | TCHER | | | 2. DATE OF DEATH DEC 10 | ** 1990 *' | 3. TIME OF OEATH 9:45 am M |
| 4. SOCIAL SECURITY NUMBER 214-05-9876 | 1 ¼ M 2 □ F 87 | | INTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | 03 | BIRTHPLACE (State or Foreign Country) MARYLAND |
| 9a. FACILITY NAME (If not institution, give s FROSTBURG NURSIN | | 91 | FROSTB | URG | тн | 9c. COUNTY | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT MADAZI AND | | | OWN OR LOCAT | ION | | | 10d. INSIDE CITY |
| 10e. STREET AND NUMBER | EGANY | CUME | 1 | ZIP CODE | | 10g. CITIZEN | 1 X YES 2 NO |
| 537 EASTERN A | 12. WAS DECEDENT EVER I | N U.S. ARMED | 13. WAS DEC | 21502 ENDENT OF HISPANI | C ORIGIN? (Specify Yea | U.S | A. RACE — American Indian, |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES | 2 NO ATES | If yes, spe | 2 NO Specify: | Puerto Rican, etc.) | | Black, White, etc. Specify: WHTTF. |
| 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5+) | 16a. DECEDENT'S USI (Give kind of work life. Do NOT use re | done during mo: | N at of working | 16b. KIND OF BUS | SINESS/INDUST | |
| 17. FATHER'S NAME (First, Middle, Last) | | KELLY SPRI | INGFIEI | | TIRE | E MANF. | |
| WILLIAM HENRY 19a. INFORMANT'S NAME (Type/Print) | FLETCHER | 19h MAII ING AD | DBECC /Street | JESSI LI | EE BAXTER | | |
| SHIRLEY WIGFIELD | | RFD# 9 F | 30X# 29 | 3 WILLIAN | AS ROADCUM | | |
| 1 Buriel 2 Cremation 3 Rame 4 Donation 5 Other (Specify) | H | other place) ILLCREST F | | | | CATION — CITY SERLAND | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE WATER | + | 0.00000 1470000 | ADDRESS OF FACE X-MERRITT | RELINERALM REET COMB | 201 - 111 | |
| 23. PART I. Enter the diseases, or cahock, or heart failure. | complications that caused List prity one cause on e | d the death. Do not a | enter the mod | se of dying, such | as cardiac or respi | ratory arrest, | Approximate Interval Between |
| immediate cause (Final disease or condition resulting in death) | Cando | ne ar | MI | 7 | | | OnseCand Death |
| Sequentially list conditions, | Ar Les | CONSEQUENCE OF | ent | 20 | | L | Pers |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | DUE TO (OR AS A | CONSEQUENCE OF) | | | | | 0 |
| that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | | |
| PART II. Other significant condition | contributing to death b | ut not resulting in th | ne underlying | cause given in Pr | ert I. 24a, WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS MINLABLE PRIOR TO |
| 7 | | | | | _ 1 □ YES 2 | 575760 | OF DEATH? |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ICE OF DEATH (Chick | ant and | | 1 D YES XNO |
| EXAMINER? 1 ☐ YES 2 ☑ NO 27. MANNER OF DEATH | HOSPITAL: 1 ☐ Inpetient 2 ☐ ER/Outp 38s. DATE OF INJURY | | HER: XNursing Home | 5 🗆 Residence é | Other (Specify) | | |
| 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Year) | INJURY | M 1 TY | | 8d. DESCRIBE HOW IN | JURY OCCURE | D |
| 3 Suicide 8 Could not be 4 Homicide detarmined | building, etc. (Spec | — At home, farm, street | , factory, office | | Bf. LOCATION (Street at City or Town, State) | nd Number or R | ural Route Murities, |
| (Check only 1 X CERTIFY OF PHYSIC ONE) 2 MEDICAL EXAMINES | CIAN: To the best of my knows to On the basis of exemination | edge, death occurred at and/or investigation, in | the time, date a my opinion, de | and place, and due to | the cause(s) and man- | her as stated. | usedki) and manner as stated. |
| 296. SIGNATURE AND TITLE OF CENTREEN | | 0 | M | 29c LICENSE NUMBE | | 29d. DATE SIG | INTO CAMPANA CHARLE VALLEY |
| DR. GUY FISCUS | 500 MENORIAL | | |). MARYLAI | ND 21502 | 710 | tiolio |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hispital physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. If be filled within 72 hours after death with the State Dept. of Health and Mental Hydrine prior to burial, cremation, or removal.

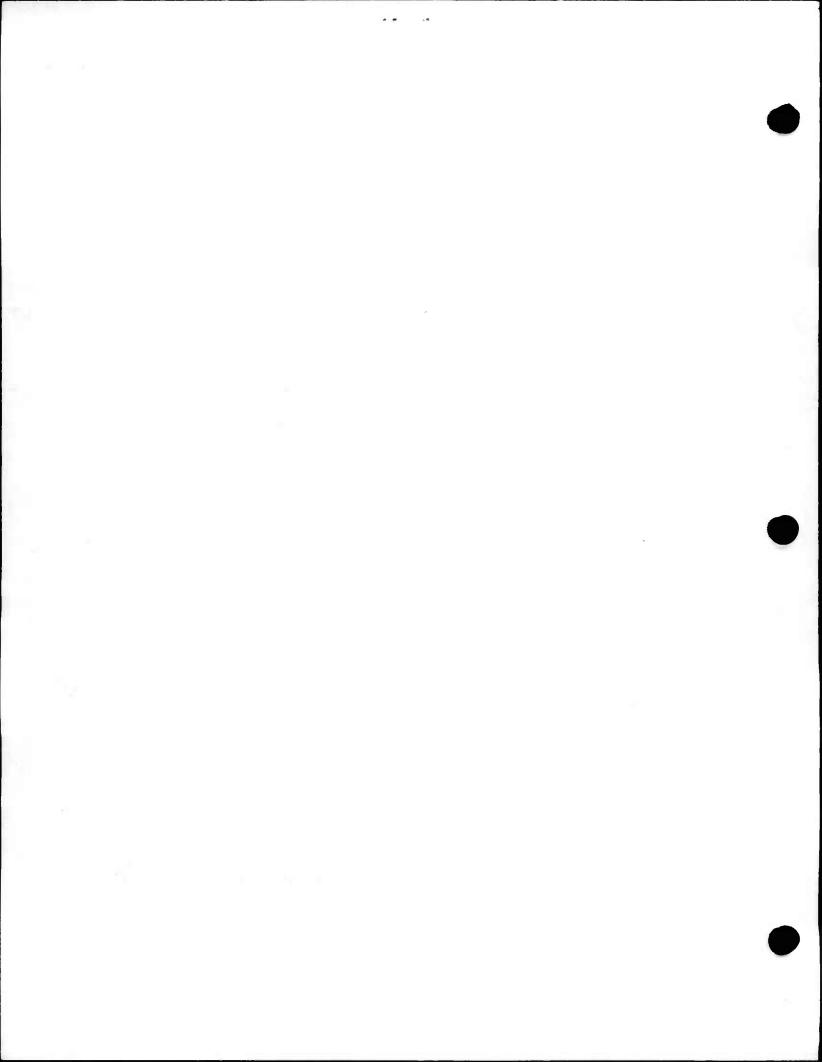
IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-16 Rev 1/89

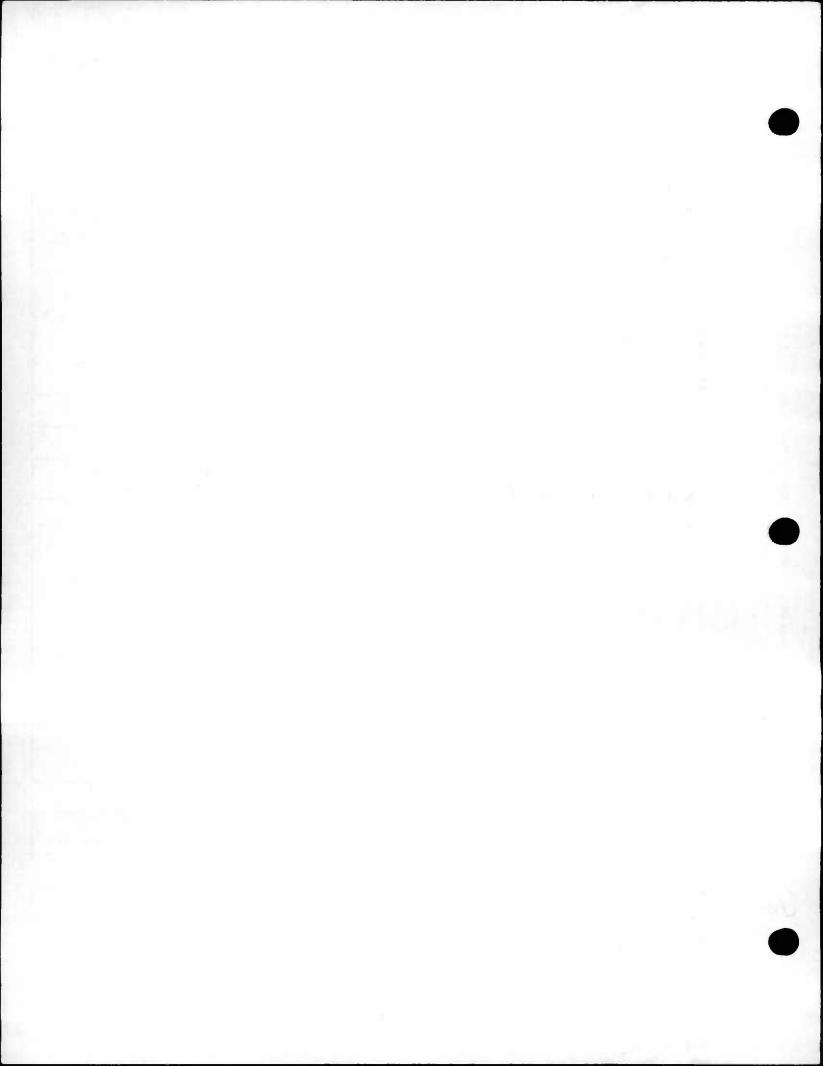


BALTIMORE, MARYLAND 21203-3146

IN THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-flours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transt be filed within 72 hours after death with the State Dept. of Health and Merital Hydiene prior to burlal, cremation, or removal.

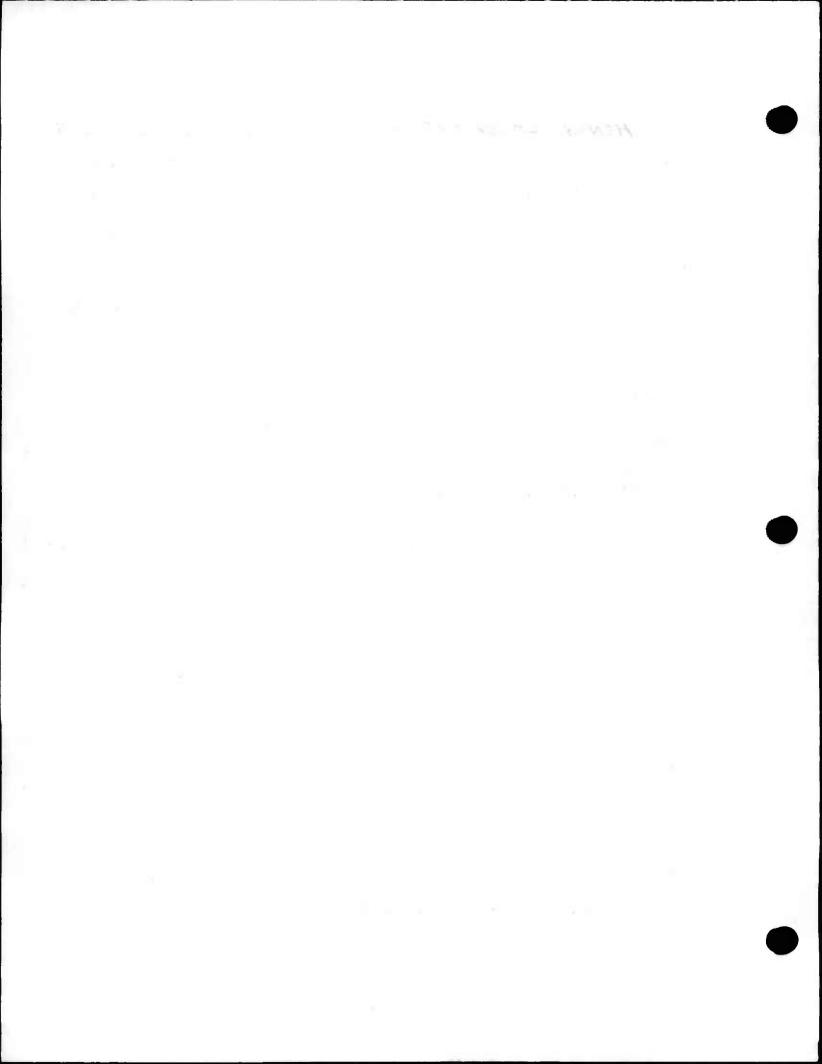
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | REGISTRAN | | | | SHIIF | ICATE | OF DE | AIR | REG. | NO. | | | |
|---------------|---|----------------------------|--|---|-------------------------------------|--|-----------------------------------|---|---|-------------------------|----------------------------|--|--|
| ! | 1. DECEDENT'S NAME (First, | Middle, Last) Sarah | | E. | | Flect | cher | | 2. DATE OF DEAT | DAY | YEAR | 3. TIME OF DEATH | |
| | 4. SOCIAL SECURITY NUME 578-34-3349 | ER | 5. SEX | 6. AGE (In yrs. le: | yrs. | IF UNDER 1 Y | EAR IF UN | DER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Yea 11 03 | , | 6. BIRTH Countr | PLACE (State or Foreign | |
| | 9e. FACILITY NAME (If not in | stitution, give s | treet and number) | | 9b. CITY, TOWN OR LOCATION OF DEATH | | | | | _ | 9c. COUNTY OF DEATH | | |
| DIRECTOR | 1802 Allen | | burt | | 7.1 | | | | | | nce George's | | |
| 2 | RESIDENCE OF DEC | 10b. COUNT | Y | | 10c CIT | Y, TOWN OR | OCATION | | | | | | |
| | Maryland | | ce George | 's | | lmer | | | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO | |
| FUNERAL | 1802 Allen | dale | Court | | | | 101. ZIP C | 20785 | | 10g. CI | TIZEN OF V | WHAT COUNTRY? SA | |
| B | 11. MARITAL STATUS 1 Never Married 2 Style Widowed 4 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | MED NO | 13. WA | DECENDEN s, specify 6 YES 2 | T OF HISPAN uben, Mexica NO Specify | IIC ORIGIN? (Specify n, Puerto Rican, atc. | Yes or No—) | 14. RACE Black Sport | E — American Indian, k, white, atc. Black | |
| | 15. DEC | EDENT'S EDU | CATION | 18a, DE | CEDENT'S | USUAL OCCI | PATION | | 16b. KIND OF | BUSINESS/IN | DUSTRY | | |
| COMPLETED | Elementary/Secondary (0 | highest grade -12) | College (1-4 or 6 | illie Illie | . Do NOT us | work done duri se retired.) .C WOY | - | orlding | | Priva | te | | |
| Š | 17. FATHER'S NAME (First, M | | | | | | 18. M | OTHER'S NA | ME (First, Middle, Me | iden Sumame) | | | |
| BE | Abrahai | | Pink | | | | | Sara | | Ode | | | |
| ٩ | Mary Carte | r | | 40 | 038 H | lanson | Oak 1 | Or/Lar | Route Number, City of adover Hi | Town, State, 2 | 2078 | 34 | |
| | 20 METHOD OF DISPOSITI | (Specify) | | 20b. PLACE other p | of Dispos | gton [Name | of cometery, o | nal Ce | metery | LOCATION - | | on, VA | |
| | SIGNATURE OF FUNERAL | L SERVICE LIC | Deal. | 8. | | | | ness of fac | RD/Lando | Jenk ver M | | | |
| | 23. ART I. Enter the di ahock, or his MEDIATE CAUSE (Fin disease or condition resulting in death) | soit ignore. | . Care | t caused the de de de de de de de de de de de de de | Imo | na | e mode of | dying, suci | h as cardlec or re | eapiratory a | rreat, | Approximate Interval Between Onset and Death | |
| CERTIFICATION | Sequentially list conditi if any, leading to immediates. Enter UNDERLY! CAUSE (Disease or inju- that initiated events resulting in death) LAS | diate NG ry | a Myli | (OR AS A CONSE | | uje | lou | ra | - | | | Chronic | |
| | PART II. Other algnifica | nt condition | a contributing to | death but not | reaulting | In the unde | riving caus | e given in | Part I. 24a, WM | AN AUTOPSY | 24h | WERE AUTOPSY FINDINGS | |
| MEDICAL | - N. - De | all | outo | non | | | | | PEF | FORMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | |
| ž | | | | | | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | OTHER: | 6. PLACE O | F DEATH (Chi | ock only one) | | | | |
| ¥S. | 1 TYES 2 NO | | 1 Inpatient 2 | | □ DOA | | Home 6 | Residence | 6 Other (Specify) | | | | |
| ВУ РН | | Pending investigation | 28a. DATE OF (Month, D | | 26b. TIM INJ | URY | WORK? | | 28d. DEŞCRIBE HO | W INJURY O | CCURED | | |
| | 3 Suicide 6 : | Could not be determined | 28e. PLACE O building, | F INJURY — At ho | me, farm, s | street, factory | office | | 261. LOCATION (Str. City or Town, S | eet and Number tate) | or or Rural F | Route Number, | |
| COMPLETED | | | CIAN: To the best of R: On the basis of a | | | | | | | | | a) and manner se stated. | |
| H C | 29b. SIGNATURE AND THE | OF CERTIFIER | 1 | | | | 29c. I | JCENSE NUW | IBER | 29d. DA | TE SIONED | (Month, Day, Year) | |
| <u>و</u> | -cup | up | and | 16 | | | I | -32 | 332 | • | 11/ | 21/00 | |
| F | 30, NAME AND ADDRESS OF | PERSON WH | O COMPLETED CAU | SE OF DEATH (ITE | М 27) (Туре, | Print) | SK | G | UP | TA | 7 | | |
| | 9701 G | Year) | 932: REGISTRA | AT'S SIGNATURE | (2) | 0 | Silv | er S | ing N | d | 200 | 702 | |
| - 4 | I MATE DA | 199 | Sulia | Davidson- | Pandal | 2 | | | | | | | |



| be retained by the hospital or attending physician | ge 5 should be detached for use as the burial-transit permit. Pag | e notified at once. |
|---|--|---|
| IV HE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or arren | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notifi |

| | HEGISTRAR | RYLAND / DEPARTM CERTIFIC | MENT OF HEALTH AND | MENTAL HYGIENE REG. NO. | 90 34365 | | | | | | | | |
|--------------------|---|---|--|---|--|--|--|--|--|--|--|--|--|
| | | V FITZG | ERALD | 2. DATE OF DEATH MONTH DAY | YEAR 90 5 A N | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 226-44-45_14 1 1 1 M 2 F | 8. BIRTHPLACE (State or Foreign Country) Virginia | | | | | | | | | | | |
| TOR | 226-44-4514 19 M 2 F 52 YRS. MONTHS DAYS HOURS MIN. MONTH, Day, Year 3-15-38 VIII 9a. FACILITY NAME (If not institution, give street and number) 6724 Eldridge Street HYATTS VILLE PRINCE | | | | | | | | | | | | |
| DIRECTOR | MD Prince Geo | 10d. INSIDE CITY LIMITS? 1 X YES 2 \(\square\) NO | | | | | | | | | | | |
| FUNERAL | 10. STREET AND NUMBER 6724 Eldridge It | reet | 10f. ZIP CODE 207 | 84 | 09. CITIZEN OF WHAT COUNTRY? USA | | | | | | | | |
| ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. WAS DECEDENT E FORCES? 1 FORCES? 1 FYES, GIVE WAR | YES 2X NO | 13. WAS OECENDENT OF HISP/ if yes, specify Cuben, Mexic 1 YES 2 NO Specify | cen, Puerto Rican, etc.) | No— 14. RACE — American Indian, Black, White, etc. Specify | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondpry(0-12) College (1-4 or 5 +) | 16a. DECEDENT'S USU (Give kind of work of the Do NOT use reto Maintenat | done during most of working tired.) | 16b. KIND OF BUSINE | ESS/INDUSTRY | | | | | | | | |
| DMF | 17. FATHER'S NAME (First, Middle, Last) | ratification | | | Private | | | | | | | | |
| | Tolon | zgerald | 18. MOTHER'S N | IAME (First, Middle, Melden Sun | | | | | | | | | |
|) BE | 19e. INFORMANT'S NAME (Type/Print) | | DRESS (Street and Number or Rura | | mack | | | | | | | | |
| 욘 | Catherine Woll | | ldridge St/Hy: | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 N Series 2 Cremetion 3 Removal from State | 20h PLACE OF DISPOSITIO | M /Mama of sametas | | 10N — City or Town, State | | | | | | | | |
| | 4 Donetion 5 Other (Specify) 2 SIGNATURE OF FUNERAL SERVICE LICENSEE | Harmor | ny Memorial Pa | rk La | undover, Md | | | | | | | | |
| | Summy 6 Dear | ls | | TAN TRUITING INFO | us Funeral Home | | | | | | | | |
| | 23. PART I. Enter the diseases, or complications that conshock or heart failure. List only one cause | aused the death. Do not a on each line. | inter the mode of dying, sur | ch aa cerdiac or reapireto | ory arrest, Approximate | | | | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) a. Carcino ma of Europhagus Due to (or as a consequence or): | | | | | | | | | | | | |
| 7 | DUE TO (OR | AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CATIO | csuse. Enter UNDERLYING | R AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | R AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | PART II. Other significent conditions contributing to dea | eth but not reculting in th | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | | thi but not recuting in an | e underlying ceuse given in | 1 Part I. 24e. WAS AN AUTH PERFORMED 1 TYES 2 | MAILABLE PRIOR TO | | | | | | | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | | 28. PLACE OF DEATH (C) | heck only one) | | | | | | | | | |
| IXSI | 1 YES 2 NO 1 Inpatient 2 ER | VOutpatient 3 DOA 4 D | HER: Nursing Home 5 Residence | 8 Other (Specify) | | | | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | (agr) INJURY | 28c. INJURY AT WORK? M 1 YES 2 NO | 28d. DEŞCRIBE HOW INJUR | RY OCCURED | | | | | | | | |
| | 4 Homicide determined | | | City or lown, State) | lumber or Rural Route Number, | | | | | | | | |
| COMPLETED | (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my one) 2 MEDICAL EXAMINER: On the basic of exami | knowledge, death occurred at t nation end/or investigation, in | the time, date end place, and due my opinion, death occured at the | to the ceuse(e) end menner of time, date end place, end due | ee stated. e to the ceuse(e) end menner ee stated. | | | | | | | | |
| 10 BE | 296. SIGNATURE AND TITLE OF CERTIFIER Daylaberth | eputy Med Examine | 29 LICENSE NUM | P\$ 2 29d | S. DATE SIGNED (Month, Day, Yeer) | | | | | | | | |
| | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF PAUL A. DEVORE M.D. 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S: | 4 203 QU-001 | sbury Rd | Hyatstu | 1. DATE SIGNED (Month, Day, Year) 11-27-90 11/e MD 2078/ | | | | | | | | |
| | NOV 3 0 90 June Davidson | | | | | | | | | | | | |

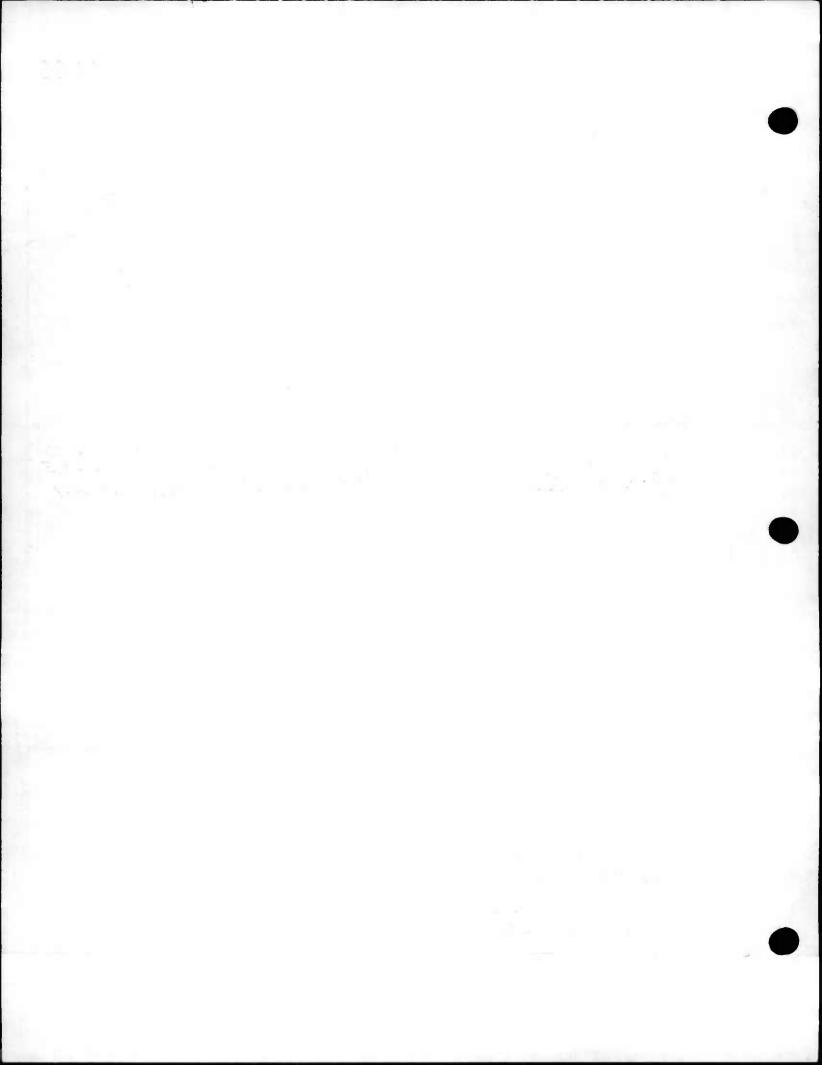


BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| | 1.0000000000000000000000000000000000000 | | | | | BIII | ICAI | E UF | DEA | <u>III</u> | | REG. NO. | | | |
|---------------------|--|------------------------------|---------------------------|----------------------------|-------------------|---------------|--------------|-------------|---------------------|------------|-------------------------|---------------|------------------|-------------|-------------------------------------|
| | 1. DECEDENT'S NAME (First, | , | | | | | | | | | 2. DATE OF | F DEATH DA | | | 3. TIME OF DEATH |
| | Harry W | I. Fo | rster, s | Sr. | | | | | | | MONTH | | | YEAR | 0 45 74 |
| | 4. SOCIAL SECURITY NUMBER | ER | 5. SEX | | (in yrs. ias) | l birthday) | IF UNDE | ER 1 YEAR | I I INDE | R 24 HRS. | 7. DATE OF | | 6, | 1991 | |
| | 216 60 0201 | | 1 🔀 M 2 🗆 F | 11111111111 | | | MONTHS | | HOURS | MIN. | 7. DATE OF (Month, E | | | 8. BIRTH | PLACE (State or Foreign y) |
| | 216-68-8301 | | | 6 | 52 | YRS. | | | | | Apr. | 19, 1 | 1928 | Mar | yland |
| | 90. FACILITY NAME (If not ins | | 9b. CIT | Y, TOWN | OR LOCATI | ION OF D | | | | INTY OF DE | | | | | |
| BY FUNERAL DIRECTOR | Franklin So | nare | Unenital | | | | Tre | | | | | | _ , | | |
| 5 | Franklin Sq | EDENT | nuspitai | | | | LS | sex | | | | | Bal | timo | ore |
| ĬĬ. | 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | | | | | | | | | | | | 10d. INSIDE CITY | | |
| 5 | | | | | - 1 | | | | | | | | | | LIMITS? |
| 7 | Maryland 100. STREET AND NUMBER | Anne | Arundel | | | G1 | en B | urni | | | | | | | 1 YES 2 NO |
| × | | | | | | | | 101 | H. ZIP COD | Æ | | | 10g. CIT | IZEN OF W | HAT COUNTRY? |
| ii ii | 608 Kuethe | Rd. | | | | | | | 2106 | 0 | | | ,,, | C 7 | |
| 5 | 11. MARITAL STATUS | | 12. WAS DECEDEN | T EVER I | IN U.S. ARI | MED | 13 | | | | ANIC ORIGIN? (| | | S.A. | |
| 1 | 1 Never Merried 2 1 | Merried | FORCES? 1 | YES | 2 N | 10 | | If yes, sp | pecify Cube | en, Mexico | en, Puerto Rice | en, etc.) | or No- | Black | - American Indian, , White, etc. |
| BY | 3 Widowed 4 Divorce | cod | IF YES, GIVE W | | ATES | | | 1 TYES | 8 2 € NO | Specif | lfy: | | - 1 | Specif | ly: |
| | 15 DECE | TOTAL EDI | | W 2 | | | | | | | | | | Wh | ite |
| COMPLETED | (Specify only | EDENT'S EDU highest grade | e completed) | | (Gh | CEDENT'S | work done | during mo | ON ost of worlds | Ina | 16b. KI | IND OF BUS | SINESS/INC | DUSTRY | |
| Ш | Elementary/Secondery (0- | | College (1-4 or 5 + | +) | life. | Do NOT us | se retired.) | dorning | 10t un 17 | N/ | | | | | |
| 후 | Ω | | | 1 | mr, | rale I | n-177 | ~ ** | | | 77.00 | | | | |
| 0 | 17. FATHER'S NAME (First, Mid | ddle. Lest) | | | | uck I | JEIVE | er | T | | | nspo | | ion | |
| | | | | | | | | | 18. MOT | HER'S NA | AME (First, Midd | de, Maiden | Surname) | | |
| H | Harry Forst | | | | | | | | _Aı | nna | Heath | | | | |
| 2 | 19e. INFORMANT'S NAME (Typ | pe/Print) | | | 19b | . MAILING | ADDRES | S (Street & | | | Route Number, | City or Tow | n State, Zit | n Code) | |
| 7 | Betty R. For | retor | | | | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITIO | | | 1 201 | | 308 r | (ueti | 16 K | d., (| Glen | Burni | | | | |
| | 1 Buriel 2 Cremation | n 3 🗆 Rem | noval from State | | b. PLACE O | 9C0) | | | | | | 20c. LO | CATION — | City or Tow | wn, State |
| | 4 Donation 5 Other (| | | - C | Glen | Have | en Me | emor | ial J | Park | | Glei | n Bur | cnie. | A.A., MD |
| | 21. SIGNATURE OF FUNERAL | PERVICE LIC | CENSEE | | | | | | ND ADDRE | | | 1 | | , | IX. IX. / LIL |
| | Carthar Line | 1,). | 111 | 421 Crain Hwy. S.E. | | | | | | | | | | | |
| | 1 south 1 | 7120 | 4 seld | Glen Rurris Maryland 21061 | | | | | | | | | | | |
| | 23. PART I. Enter the dis | seesea, or (| complications the | t causer | d the der | eth. Do r | not anter | the me | de of dy | ing sur | ch as cardia | anu . | TUOL | - 1.04 | . I a sanitanta |
| | anock, or nee | art lallure. | List only one cau | se on e | ech lina. | | | | 40 0. 5, | mai and | All de Column | ; Or respir | retory an | est, | Approximate interval Between |
| | IMMEDIATE CAUSE (Fins | | | | | | | | | | | | | | Onset and Deeth |
| | disease or condition resulting in death) | → | Ischemi | LC H | lear | t D | isea | ase | | | | | | | 141 Com |
| | | | | | | SEOUENCE OF): | | | | | | | | | - |
| - 1 | | _ | Arterio | 2001 | laro | +10 | Car | -210 | | ~7 | D: | | | | |
| ō I | Sequentially list condition | oris, | Arterio |)DCT | A CONSEQU | LIC | Cai | aro | Vas | Cur | ar_bi | seas | e | | |
| E | If sny, lesding to immedicause. Enter UNDERLYIN | | 000.00 | וסח אם א | CONSEC | UENCE OF | 7): | | | | | | | | |
| 2 | CAUSE (Disease or Injury | | с | | | | | | | | | | | | |
| # 1 | that initiated events | | DUE TO | (OR AS A | A CONSEOL | UENCE OF | ř): | | | | | | | | |
| E | resulting in death) LAST | | ū | | | | | | | | | | | | |
| CERTIFICATION | | | d | | | | | | | | | | | | |
| ا پ | PART II. Other significant | t condition | a contributing to | death b | ut not re | auiting ! | in the ur | nderlying | ceuse (| alven in | Part I. 24 | a. WAS AN | AUTOPSY | 24h | WERE AUTOPSY FINDINGS |
| 2 | Anoxic Ence | | | | | | | | | , | | PERFORI | | 1000 | AWAILABLE PRIOR TO |
| MEDICAL | MIOVIC PHO | Spirar | LOPACITY | | | | | | | | 1/ | ☐ YES 🗶 | XNO | | COMPLETION OF CAUSE OF DEATH? |
| Z | | | | | | | | | | | 1 | | | | 1 ☐ YES 2 ☐ NO |
| | | | | | | | | | | | _ | | | | 1 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO | MEDICAL | | | | | | 20.51 | | | | | | | |
| 고 □ | EXAMINER? | M.Co. | HOSPITAL: | | | | OTHER | | ACE OF DE | EATH (Ch | heck only one) | | | | |
| YS | 1 TES 2 NO | | HOSPITAL: | ER/Outp | intlent 3 | □ DOA | | | e 5 □ Re | eidence | 8 Other (Sp | pecify) | | | |
| Ŧ | 27. MANNER OF DEATH | | 28e. DATE OF | INJURY | | 28b. TIME | E OF | 28c. INJL | URY AT | | 28d. DESCRI | | LILIRY OCC | CURED | |
| 2 | 1 Natural 5 Pr | | (Month, Da | ly, Year) | | INJ | URY M | WOR | PRK? | 7 1 | | DE ITE. | loon oc | /UNED | |
| B⊀ | a Accident | rvestigation | 22: 81 405 0 | 22 1 14 fmag | | | | | | NO | | | | | |
| 0 | | ould not be | 28e. PLACE OF building, a | INJURY etc. (Spec | — At hom cify) | se, ferm, a | dreet, fact | ory, office | b | 1 | 28f. LOCATIO | ON (Street at | nd Number | or Rural Ro | oute Number, |
| COMPLETED | 4 Homicide de | etermined | | | | | | | | 1 | Uni, U | Mil, Giule, | | | |
| 3 L | 29e. CERTIFIER | THE PHYSI | | | | | | - | | | | | | | |
| 를 | (Check only one) | YING PHISIC | ICIAN: To the best of a | my knowle | ledge, deat | th occurre | d at the 1 | ime, date | end plece, | , end due | 10 The couse(| e) end man | nor as atat | ed. | |
| ō | 2 MEDICA | AL EXAMINE | R: On the basic of ex | amination | n end/or im | rvestigation | n, In my c | pinion, dr | eath occur | red at the | time, date enc | d place, enr | d due to th | e ceuse(e) | end manner as stated. |
| | 296. SIGNATURE AND TUTLE O | | | - | - /7 | | | | | | | | | | |
| 띪 | 11.1110 | Les | total | 1 | | sider | | | 29c. LICE | ENSE NUM | | | 29d. DATE | / / | Month, Day, Year) |
| | 1 Cherry | DUC | Carr | Jons | - P1 | bassi | cias | ~ | DS | 47 | 71 | | P /. | 2/6/ | 93 |
| - | 30. NAME AND ADDRESS OF F | PERSON WHO | O COMPLETED CAUS | OF DE | ATH (ITEM | 274 (Type, | Print) | | | | | | | -101 | |
| | Rudolph | Cane | M.D. | | | 91 | 200 | Era | ~ le 7 : | in (| ~ D | | D-14 | _ | 03007 |
| | 31. DATE FILED (Month, Day, Ye.) DEC 0 | | | are elGN/ | ATTIME. | 20 | 100 | Fla | UKTI | LII c | Sq. Di | C . , | ватт | <u></u> | 21237 |
| 22- | 0000 | 7 199 | O Fishe Da | ind Am | 1- Asn | delle | | | | | | | | | |
| Ţ | 13E C () | / 199 | THE THE WALL BUT | | | | | | | | | | | | |

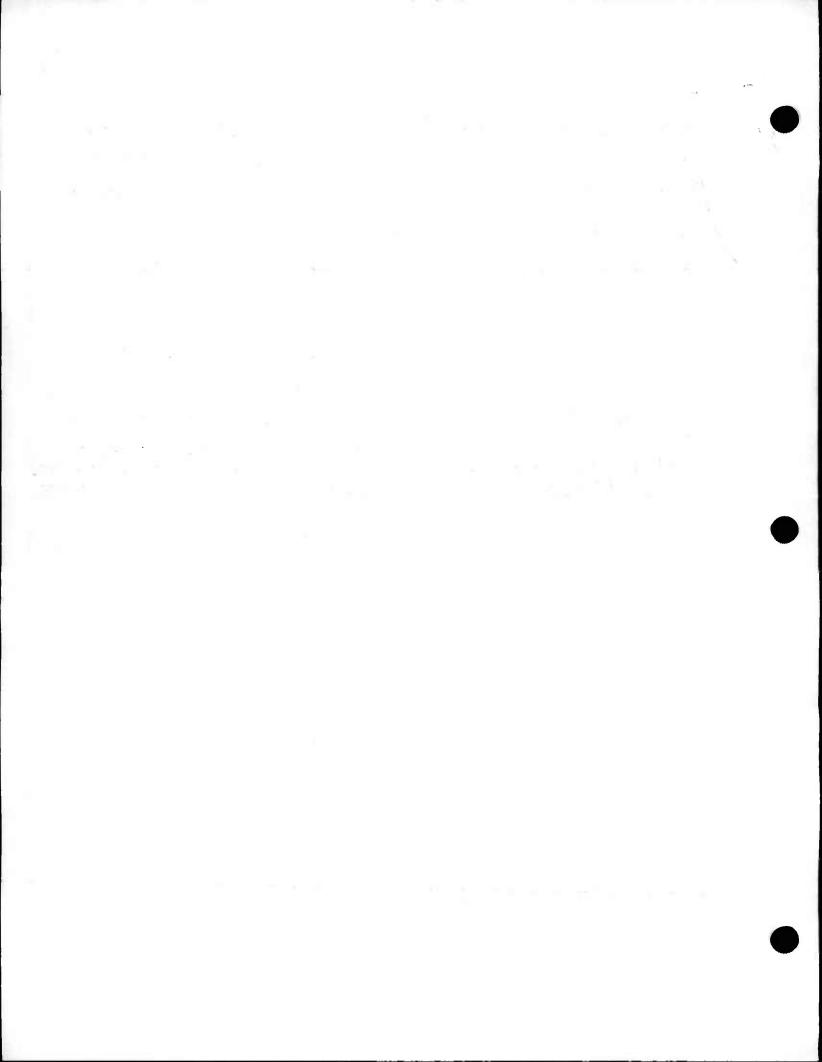


IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | SIAIL OF MAILE | CERTIF | ICATE O | HEALTH AND I | MENTA | REG. NO. | | |
|---|---|--|---|---|--|---|--|--|
| 1. DECEOENT'S NAME (First, Middle, Last) | TNCTON CDIM | 7 | | | MONT | E OF DEATH | | 3. TIME OF DEATH |
| SALLIE CABEL CARR 4. SOCIAL SECURITY NUMBER | | In yrs. last birthday) | IF UNDER t YEAR | R IF UNDER 24 HRS. | NOV | . 30. | 1990 | 09:25 PM M BIRTHPLACE (State or Foreign |
| 214-30-2368 | □ M 2 💢 F 5 | 7 YRS. | MONTHS DAY | 1 | (Mon | th, Day, Year) 5–1933 | | Country) ARYLAND |
| 99. FACILITY NAME (If not institution, give street 15849 LIVINGSTON R | , | | | N OR LOCATION OF D | EATH | | 9c. COUNTY | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | UAD | 400 017 | ACCOKE | | | | PRIN | E GEORGE'S |
| | GEORGE'S | | CCOKEE | | | | | LIMITS? |
| 10e. STREET AND NUMBER 15849 LIVINGSTON R | OAD | | | 10f. ZIP CODE | | | 17 | OF WHAT COUNTRY? |
| | 2. WAS DECEDENT EVER II | N U.S. ARMEO | 13. WAS E | 20607 DECENDENT OF HISPAN | NIC ORIGI | N? (Specify Yes | or No.— 14. | . RACE American Indian. |
| 1 Never Merried 2 Merried 3 Wildowed 4 M Divorced | FORCES? 1 YES | | If yes, | specify Cuban, Mexico ES 2 N NO Specif | an, Puerto ly: | Rican, etc.) | | Specify: WHITE |
| 15. DECEDENT'S EDUCA (Specify only highest grade co | mpleted) | t6a. DECEDENT'S (Give kind of life. Do NOT u | work done during | | 16 | b. KIND OF BUS | INESS/INDUS | ТЯУ |
| 12TH GRADE | College (1-4 or 5+) | PROGRAM | | SPEC. | | US GO | VT. E | DUCATION |
| 17. FATHER'S NAME (First, Middle, Last) | DALIE | | | 18. MOTHER'S NA | | | Surname) | |
| WILLIAM ELLIOTT 190. INFORMANT'S NAME (Type/Print) | RUWE | 195. MAIL INC | G AODRESS (Street | SUE BE | | | State 7lo Co | orie) |
| WILLIAM E. GRIMES | | 1.00 | | STON ROAL | | | | |
| 20e METHOO OF DISPOSITION 1 A Burial 2 Cremation 3 Remove | al from State | other place) | | cemetery, crematory or | | 1.51 | | or Town, State |
| 21. SEARTHRE OF FUNERAL SURVICE LINES | - | RINITY M | | AND ADDRESS OF FA | ACILITY 7 | THE HIM | DUKF. | MARYLAND IERAL HOME,INC. |
| · Well KB | le l | 7 | | | | | | ND 20604-0156 |
| 23. PART I. Enter the diseases, or co shock, or heart fallure. Li | mpilcetione that cause | the death. Do | | | | | | |
| shock, of fleat failule. Li | | | | , ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | | |
| iMMEDIATE CAUSE (Finel | | | W 7 WA | | | | | interval Batwaen Onset end Death |
| iMMEDIATE CAUSE (Finel disease or condition resulting in death) | Reutal ad | | ma Cill | hetartases | | | | interval Batwaen Onset end Death |
| disease or condition resulting in death) | Reutal Odl OUE TO (OR AS | (h) Carcin " a consequence of | OF): | | | | | interval Batwaen Onset end Death |
| diseese or condition | Reutal Odl OUE TO (OR AS | Cho Carcino | OF): | | | | | interval Batwaen Onset end Death |
| Sequentially list conditions, if eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events | OUE TO (OR AS | (h) Carcin " a consequence of | OF): | | | | | interval Batwaen Onset end Death |
| Sequentially list conditions, If eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury | OUE TO (OR AS | A CONSEQUENCE O | OF): | | | | | interval Batwaen Onset end Death |
| Sequentially list conditions, if eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A | A CONSEQUENCE O | DF): DF): | hetartares | to va | 24a. WAS AN PERFOR | AUTOPSY MED? | Interval Batwaen Onset end Death Alarys 3 yrs 6 mg/s. |
| diseese or condition resulting in death) Sequentially list conditions, if eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS A | A CONSEQUENCE O | DF): DF): | hetartares | to va | y'ha, l | AUTOPSY MED? | interval Batwaen Onset end Death Onset end Death Allows 3 40 6 Mg/s. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| diseese or condition resulting in death) Sequentially list conditions, if eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Diseese or injury that initiated events resulting in deeth) LAST | DUE TO (OR AS A | A CONSEQUENCE O | DF): DF): | hetartares | to va | 24a. WAS AN PERFOR | AUTOPSY MED? | interval Batwaen Onset end Death Onset end Death Onset end Death Onset end Death Onset end Onset |
| Sequentially list conditions, if eny, leading to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditione | DUE TO (OR AS A | A CONSEQUENCE O | DF): DF): In the underly | hetartares | Part I. | 24a. WAS AN PERFORI | AUTOPSY MED? | interval Batwaen Onset end Death Onset end Death Allows 3 40 6 Mg/s. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| Sequentially list conditions, if eny, laeding to immediate ceues. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 X NO | DUE TO (OR AS A | A CONSEQUENCE CONS | DF): DF): In the underly 26 OTHER: 4 \(\text{Nursing is} \) | ving cause given in | Part I. | 24a. WAS AN. PERFORI 1 YES 2 | AUTOPSY MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, leading to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditione 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 N Natural 5 Pending | DUE TO (OR AS A | A CONSEQUENCE C | OTHER: 4 Nursing I | ving cause given in PLACE OF OEATH (C) From 5 X Residence INJURY AT WORK? | Part I. | 24a. WAS AN. PERFORI 1 YES 2 | AUTOPSY MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, leeding to immediate ceues. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending Investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A CONTributing to death to Inpatient 2 ER/Out (Month, Day, Year) 28e. PLACE OF INJURY | A CONSEQUENCE C A CONSEQUENCE C A CONSEQUENCE C Dut not resulting | OTHER: OTHER: ME OF 28c. JURY M 1 | PLACE OF OEATH (CI | heck only of | 24a. WAS AN. PERFORI 1 YES 2 POR (Specify) ESCRIBE HOW IN | AUTOPSY MED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, laeding to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditione 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Nostural 5 Pending investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A CONTRIBUTING TO GENERAL SERVICE HOSPITAL: Inpatient 2 | A CONSEQUENCE C A CONSEQUENCE C A CONSEQUENCE C Dut not resulting | OTHER: OTHER: ME OF 28c. JURY M 1 | PLACE OF OEATH (CI | heck only of | 24a. WAS AN / PERFORM 1 YES 2 | AUTOPSY MED? | 24b. WERE AUTOPSY FINDINGS AWAILALE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, laeding to immediate ceues. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death to Impatient 2 = ER/Out Impatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | A CONSEQUENCE CONS | DF): DF): 26 OTHER: 4 Nursing to ME OF 28c. JURY M 1 (atreet, factory, commend at the time, of | Ving cause given in PLACE OF OEATH (C) Frome 5 X Residence INJURY AT WORK? YES 2 NO | Part I. s Oth 28d. Of | 24a. WAS AN. PERFORI 1 YES 2 CATION (Street a y or fown, State) | AUTOPSY MED? MI NO NJURY OCCUR and Number or | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, laeding to immediate ceues. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in deeth) LAST PART II. Other eignificant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death to Impatient 2 = ER/Out Impatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | A CONSEQUENCE CONS | DF): DF): 26 OTHER: 4 Nursing to ME OF 28c. JURY M 1 (atreet, factory, commend at the time, or | Ving cause given in PLACE OF OEATH (C) Frome 5 X Residence INJURY AT WORK? YES 2 NO | heck only o | 24a. WAS AN. PERFORI 1 YES 2 CATION (Street a y or fown, State) | AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? | 24b. WERE AUTOPSY FINDINGS AMAILALE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, leading to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditione 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending Investigation 3 Suicide 5 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A Contributing to death to Impatient 2 = ER/Out Impatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | A CONSEQUENCE CONS | DF): DF): 26 OTHER: 4 Nursing to ME OF 28c. JURY M 1 (atreet, factory, commend at the time, or | PLACE OF OEATH (C) OTHER SET OF SET | heck only o | 24a. WAS AN. PERFORI 1 YES 2 CATION (Street a y or fown, State) | AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? Autopsy Medical Medica | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Sequentially list conditions, if eny, leading to immediate ceuee. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other eignificant conditione 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Notural 5 Pending Investigation 3 Suicide 5 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR A DUE | A CONSEQUENCE CONS | DF): DF): 26 OTHER: 4 □ Nursing Is ME OF JURY M □ 1 [atreet, factory, c. atreet, factory, c. atreet, factory, c. | PLACE OF OEATH (C) OTHER SET OF SET | Part I. Peck only of some to the control of the co | 24a. WAS AN PERFORI 1 YES 2 DONE) PERCORIBE HOW IN CATION (Street as yor Town, State) ause(e) and man te and place, end | AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? AUTOPSY MED? Autopsy Medical Medica | interval Batwaen Onset end Death Onset end Death Onset end Death Onset end Death Onset end Death Onset end Death Onset end Death Onset end Onset e |



| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALLIMONE, MANYLAND 21203-3146 | |
|--|-----------------------|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 24 hours after death, Page 6 may be retained by the hospital or attending physician. | |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | if. Pages 1, 2, 3 ang |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | - |
| | |

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTI CERTIFIC | | | MENTAL HYGIENE REG. NO. | 31 | 0 34366 |
|---------------|--|--|---|------------------------------|--------------------------------|---|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last | C. GI | LILE | | | 2. DATE OF DEATH DAY | 28 90 | |
|) | 4. SOCIAL SECURITY NUMBER 225-34-0999 | 1 🕸 M 2 🗆 F 8 (| 6 YRS. | UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Dey, Year) Mar. 7.19 | 04 V | irthPLACE (State or Foreign ountry) irginia |
| | Meridian Nurs | | 9 | | rna Par | | Anne | Arundel |
| | 10s. STATE 10b. COUN | ne Arundel | | h e rwo | od Fore | st | | 10d. INSIDE CITY LIMITS? 1 YES 2 M NO |
| UNERAL | 100. STREET AND NUMBER 803 Robinhoo | | | | 21405 | | 10g. CITIZEN C | OF WHAT COUNTRY? |
| NOT 10 | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IF FORCES? 1 🔀 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | ENDENT OF HISPAN | IC ORIGIN? (Specify Yea n, Puarto Rican, atc.) | s | RACE — American Indien, Black, White, etc. Specify: Thite |
| | 15. DECEDENT'S ED (Specify only highest gra Elementary/Secondary (0-12) | DUCATION | 16a. DECEDENT'S US (Give kind of wor life. Do NOT use i | k done during mo etired.) | DN st of working | 18b. KIND OF BUS | | W |
| COMPLE | 17. FATHER'S NAME (First, Middle, Lest) | 5 + | Milit | ary | | Defer | | |
| 0 00 | George Grille | | | | | Route Number, City or Town | | |
| | Evelvn D. Gri | 20 | b PLACE OF DISPOSIT | ION (Name of cer | metery, crematory or | 20c. LO | CATION — City of | |
| | s. bighattine of Funeral Service | Justan | Tingron | Tayl | or Fune | metery A | el | 21401 |
| | 23. PART I. Enter the diseases, or shock, or heert fellun IMMEDIATE CAUSE (Finel disease or condition resulting in death) | e. List only one cause on a | | t antar the mo | de of dying, auc | h as cerdiec or reepi | ratory arrest, | Approximate Interval Batween Onset and Deeth |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | c. Co | A CONSEQUENCE OF: | ex | take | | | |
| MEDICAL | PART II. Other eignificant condit | ons contributing to deeth | but not regulting in | the underlying | g cause given in | Part I. 24e. WAS AN PERFOT | MED2 | 24b, WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 ER/Ou | | OTHER: | LACE OF DEATH (C) | s Cother (Specify) | | |
| ВУ РНУ | 27. MANNER OF DEATH 1 Naturat 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | RY W | JURY AT ORK? YES 2 NO | 28d. DEŞCRIBE HOW (| NJURY OCCURE | ED |
| | 3 Suicide 8 Could not 4 Homicide determined | be building, atc. (Sp | iY — At home, farm, at ecily) | reet, factory, offi | co | 281. LOCATION (Street City or Town, State) | | tural Route Number, |
| COMPLETED | (Crieck Only | IYSICIAN: To the best of my kno | | | | | | ause(a) end manner as stated. |
| TO BE C | Mich S C | wentan |) | | 29c. LICENSE NU | 21438 | 29d. DATE SI | GNED/(Month, Day Year) |
| | MUCHAEL J. La | SOMPLETED CAUSE OF DELTA M | 0 600R | 196U | EY AU | =, #120, | ANNI | APOLISMA |
| | NOV 3 0 1990 | Julia Davidson | Andelle | | | | | 21401 |

and the second of the second o

TO BE COMPLETED BY FUNERAL DIRECTOR

| PHYSICIAN: The law requires that the death certificate be executed within 24 nous after death. Page 6 may be retained by the hospital or attending physician, | this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be considered by the state having the purial burians burial burians burial burians. | or other traumatic event, the medical examiner must be notified at once. |
|---|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 news after death, Page 6 may be ret | TO THE PUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 standards after the State hand of the pure page 10 the pure the standard page 10 the pure the standard page 10 the pure the p | MPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| FOR STATE REGISTRAR | STATE OF MA | | | | HEALTH F DEAT | | MENTAL HYGIENI REG. NO. | E | | |
|--|-------------------------------|--|--|------------------------|---------------------|-------------------------|--|------------|---------------|---|
| T. DECEDENT'S NAME (First, Middle, Last) LILA B. GARLOCI | K | | | | | | 2. DATE OF DEATH DATE OF 11-26-9 | Š | YEAR | 3. TIME OF DEATH |
| 1 | SEX 6 | i. AGE (In yrs. last b | 77 | UNDER 1 YEAR | | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) 05-18-07 | | Country) | LACE (State or Foreign |
| ANNAPOLIS CONV. | | | 96 | . 180 | N OR LOCATI | | EATH | | NTY OF DE | UNDEL |
| 10a. STATE 10b. COUNTY | | | 10c. CITY, TO | | | | - | | | 10d. INSIDE CITY LIMITS? |
| 10e. STREET AND NUMBER | ARUNDEL | | <u>GAI</u> | MBRI | 10f. ZIP COD | | | | IZEN OF WI | 1 YES 2 NO |
| | PREE LA | EVER IN U.S. ARME | ED | If yes, | | OF HISPAR In, Maxica | NIC ORIGIN? (Specify Yearin, Puerto Rican, etc.) | or No- | 14. RACE | - American Indian, White, atc. |
| 15. DECEDENT'S EDUCAT (Specify only highest grade cor Elementary/Secondary (0-12) | | (Give | o NOT use re | done during tired.) | TION THOSE OF WORKE | | NSA | SINESS/INC | DUSTRY | |
| 17. FATHER'S NAME (First, Middle, Lest) JOHN C. DIRST | | | | | M | AE | ME (First, Middle, Maiden VAN HOUT) | EN | | |
| 19a. INFORMANT'S NAME (Type/Print) KELLY GARLOCK JI | ₹. | | | | | | Route Number, City or Tow CLINTON | | , | 735 |
| 20s. METHOD OF DISPOSITION 1 Seuriat 2 Cremation 3 Femove 4 Donation 5 Other (Specify) | | 206. PLACE OF Other place | NGTO | NA' | TIONA | LC | EM. ARI | LING | TON, | VA |
| 21. SIGNATURE OF PUMERAL SERVICE LICEN | all | | | | | | NERAL HOI AVE. ANN | | | |
| 23. PART I. Enter the diseases, or con- ehock, or heert feliure. Lis IMMEDIATE CAUSE (Final disease or condition resulting in death) | | | th. Do not | fa, | mode of dy | ing, suc | th as cardiac or reepi | ratory ar | - 24° | Approximate interval Between Onset and Death |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events reculting in deeth) LAST | 0 or auc | HAS A CONSEQUENT AS A CONSEQUE | ENCE OF): | <u></u> | ynl | M | mu | 4 | LIM | Juni, |
| PART II. Other algnificent conditions | contributing to d | leath but not res | suiting in t | he underl | ying ceuse | given in | Part i. 24a. WAS AN PERFOI | RMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| | IOSPITAL: | ER/Outpatient 3 | DOA 4 | THER: | | | neck only one) 6 Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF I (Month, Day | | 28b. TIME O | ٧ | INJURY AT WORK? | □ NO | 28d. DESCRIBE HOW | NJURY OC | CURED | |
| 3 Suicide 6 Could not be detarmined | 28a. PLACE OF building, e | INJURY — At hom tc. (Specify) | e, ferm, stre | et, factory, o | offica | | 28f. LOCATION (Street City or Town, State | and Numbe | er or Rural R | oute Number, |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIA (Check only one) 2 MEDICAL EXAMINER: | | | | | | | a to the cause(a) and ma a time, dete and place, as | | | and manner as ateted. |
| 29b. SIONATURE AND TITLE OF CERTIFIER | Und | 7 | ······································ | | 29c. LIC | PENSE NU | MBER X X | 29d. DA | TE SIGNED | (Month, Day, Year) |

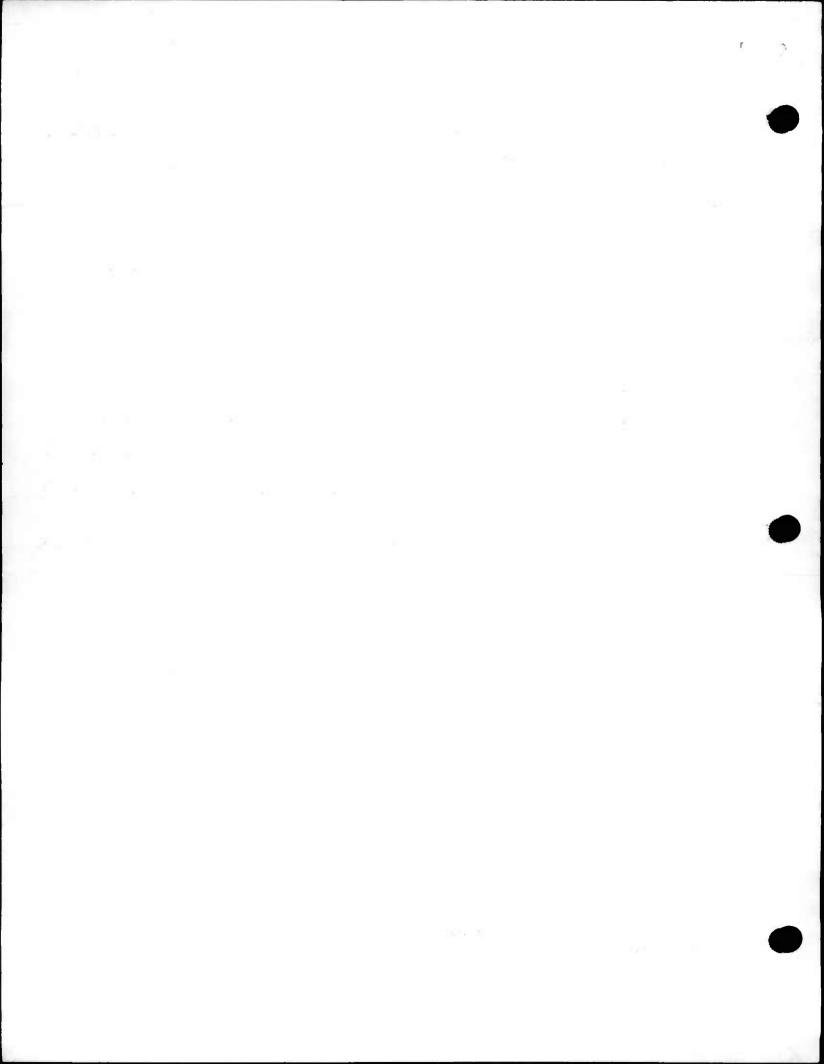
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyplene prior to burial, cremation, or removal.

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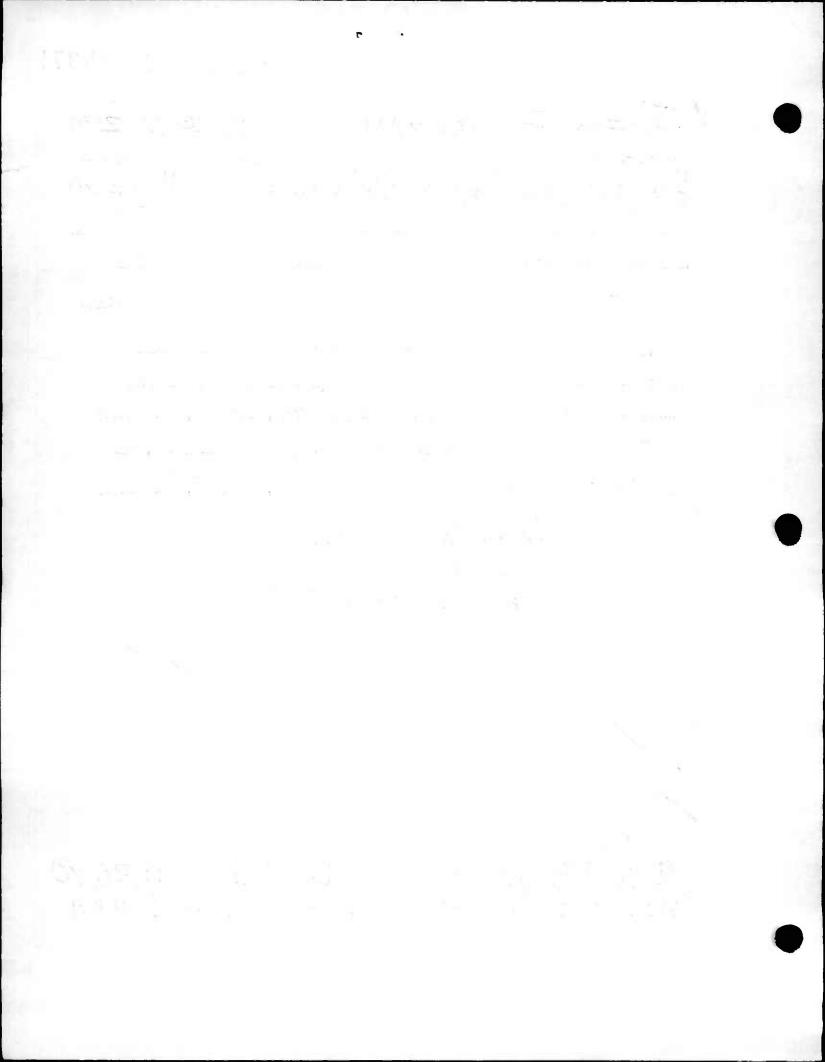
| STATE OF MARYLAND | / DEPARTMENT | OF HEALTH | AND MENTA | L HYGIENI |
|-------------------|--------------|-----------|-----------|-----------|
| | ERTIFICATE | OF DEAT | ГН | REG. NO. |

| | 1 - STATE REGISTRAR | STATE OF MARY | | | ENT OF | | | MENTAL | HYGIENE REG. NO. | | | |
|------------|---|---|-----------------------------|--------------|---------------|---------------------|-------------|--------------|----------------------------------|---------------|------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | 0.1414 | 0 001 | CCIN | | | | 2. DATE (| OF DEATH DAY | , | YEAR | 3. TIME OF DEATH |
| | AMY G GRIFT | 5. SEX 6. AGE | G. GRI | | UNDER 1 YEAR | D IE IMP | ER 24 HRS. | 7. DATE 0 | DE BIRTH | | 90 | 0750 a.M |
| ļ | 215-58-0680 | 1 M 2 AF | | | NTHS DAY | | | (Month, | Day, Year) | 07 | Count | ÉBRASKA |
| ŀ | 9a. FACILITY NAME (If not institution, give st | 96 | . CITY, TOW | N OR LOCA | TION OF DE | | 1 | 9c. COU | NTY OF E | DEATH | | |
| | CARROLL COUNTY GE | ENERAL HOSPI | TAL | | WES | TMINS | STER | | | Ci | ARRO | LL |
| | 10a. STATE 10b. COUNTY | | 1 | | OWN OR LO | | | | | | | 10d. INSIDE CITY LIMITS? |
| | MARYLAND FREDE | ERICK | | EMMI | TSBUR | 10f. ZIP CC | NDF | | | the CIT | IZEN OF | 1 TYES 2 NO WHAT COUNTRY? |
| | 100. STREET AND NUMBER 17218 BOLLINGER | SCHOOL RD. | | | | | 1727 | | | | . S. | 0.000 |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARMEI | 0 | | | OF HISPAN | | ? (Specify Yea | | 14. RAC | E - American Indian, ik, White, atc. |
| | 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR | | | | | O Specify | | , | | Spec | WHITE |
| | 15. DECEDENT'S EDU (Specify only highest grade | CATION Completed | 18a. DECEI | DENT'S US | UAL OCCUP | ATION most of wo | rkina | 16b. | KIND OF BUS | INESS/IN | DUSTRY | 1112 112 |
| | Elamentary/Secondary (0-12) | College (1-4 or 5+) | He. Do | JSEW I | etired.) | | | | OPIN | НОМ | F | 1 |
| | 17. FATHER'S NAME (First, Middle, Last) | | ПОС | JOEWI | FE | 16. M | OTHER'S NA | ME (First, A | Aiddle, Malden | | | |
| 2 | JACOB C. OLSEN | | | | | | CHRI | STINA | A PETE | RSON | | υ, |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | NI. | | | | | | | oer, City or Town | | | , MD 21727 |
| | GERALD E. GRIFFII | 1 | 06. PLACE OF | DISPOSITI | | | | OL IN | | | _ | own, Stata |
| | 1 Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | oval from Stata | SMITH: | SBURG | CREN | MATOR | IUM | | SM | <u>ITHS</u> | BURG | , MD. 21783 |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | hiles | | | | | RESS OF FA | S | KILES | | | |
| | 1 | | | | | | | | | | | 21727-0427 |
| | 23. PART i. Enter the diseases, or shock, or heart failure. | complications that cause or List only one cause or | sed the deati each line. | h. Do not | enter the | moda of | dying, suc | h ss card | tiac or reapi | retory as | rest, | Approximata interval Batween Onaet and Death |
| | iMMEDIATE CAUSE (Final disease or condition | . SEPT | ICEN | MIA | | | | | | | | IWEEK |
| | resulting in death) | DUE TO (OR A | S A CONSEOU | | | | | | W 15 | | | |
| 5 | Sequentially list conditions, | b. EMPYE | S A CONSEQUE | | G.F | the | BLA | DD | ER | | | |
| 4 | if sny, leading to immediate cause. Enter UNDERLYING | c. | | | | | | | | | | |
| RIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR A | S A CONSEOU | ENCE OF): | | | | | | | | 1 |
| S E | | d | | | | | | | | | | |
| AL | PART ii. Other significant condition | ns contributing to deat | h but not rea | uiting in | the under | lying caus | se given in | Part I. | 24a. WAS AN PERFOI | RMED? | 24 | No. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDI | | | | | | | | _ | 1 TYES 2 | MAO | | OF DEATH? 1 YES 2 NO |
| | | | | | | | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | | F DEATH (C | | | | | |
| PHTS | 1 TYES 2 NO 27. MANNER, OF DEATH | 1 Ninpatient 2 ER/0 | RY | 28b. TIME | OF 28c | . INJURY A | Rasidence | _ | SCRIBE HOW | INJURY O | CCURED | |
| 7 | 1 Natural 5 Pending 2 Accident Investigation | (Month, Day, Yea | ar) | INJUI | | WORK? | 2 🗌 NO | | | | | |
| | 3 Suicide 8 Could not be 4 Homfolde datarmined | 28a. PLACE OF INJUDENT Duilding, etc. (5 | | e, farm, atr | eet, factory, | office | | 28t. LO | CATION (Street or Yown, State | and Numb) | er or Rura | I Route Number, |
| COMPLEIED | (Check only | SICIAN: To the best of my ki | | | | | | | | | | |
| S | 2 MEDICAL EXAMIN | IER: On the basis of axamin | ation and/or in | vestigation, | , in my opini | | LICENSE NU | | a and piece, a | | | ED (Month, Day, Year) |
| BE | ach S Rud | 0- | | | | I | 21 | 150 | 2 | • | 12/ | 1/90 |
| 2 | 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF | DEATH (ITEM | | Print) AUNY | CLE | BL | QK | WEST | ጉርወያ | 57BK | 4D 21157 |
| | 31. OATE FILED (Month), 900 (bar) | ASSTEP DOORS | HENNEY | | | | | | | | | |



| | FOR | | STATE OF N | ADVI AND | / DEDAI | TMENT | ne u | CAITU | AND B | MENTAL | HAGIENI | | JU | 343/1 |
|--|---|--------------------------------|-------------------------------------|--------------------------------|---|--------------|--------------|----------------------|-------------------|--------------|---------------------------------|--------------------|-----------------------|---|
| _ | - STATE REGISTRAR | | STATE OF II | | ERTIF | | | | | | REG. NO. | | | ^ |
| | 4 SOCIAL SECURITY NUMBER | Dh | F., | GE | 2M | AA | j | # UMDER | | 7. DATE | DEATH 2 | 69 | 0 7 | CE (State or Foreign |
| - 1 | 212-05-76 | 74 | 1 0 M 2 □ F | 79 | | MONTHS | DAVE | HOURS | MIN. | | Day Year) | 1 | Country | yland |
| TOR | OW A | (OSO) | TA | C | DIE | LOCATI | ON OF DE | ATH | | SE GOUTY | OF DEATH | ARD | | |
| DIRECTOR | 10s. STATE | 10b. COUNT | , | 1-2-11 | 11111 | TY, TOWN O | | ION | 322 0 | | | 100 | 100 | I. INSIDE CITY LIMITS? |
| | Md. | Hows | ırd | | 1671 | cride | | ZIP COD | | | | 10g. CITIZEN | _ | VES 2 NO |
| ERA | 7525 Washi | ngton | Blvd. | | | | 1 | 212 | | | | nog. Grinani | USA | Cadmini |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 3 Divo | Married | 12. WAS DECEDEN | YES 2 | RMED NO | | If yes, sp | | n, Maxica | n, Puerto F | ? (Specify Yes tican, atc.) | or No— 14. | RACE — . Black, Wi | American Indian, hita, atc. white |
| | | EDENT'S EDU y highest grade | | 16a. I | DECEDENT'S (Give kind of ife. Do NOT of | S USUAL O | CCUPATIO | ON at of worki | ng | 18b. | KIND OF BUS | SINESS/INDUS | TRY | |
| COMPLETED | Elementary/Secondary (0 |)-12) | College (1-4 or 5 | ·) / | | ourit | | | | | West | inghous | 3e | |
| | 17. FATHER'S NAME (First, M. Henry H. | | | | | | | | | | Alddle, Maiden | | 4000 | |
| BE | 19a. INFORMANT'S NAME (| | L. | | 19b. MAILIN | G ADDRES | S (Street a | _ | | | | outfel | | |
| 2 | Hilda E. | German | 1 | | 7525 | Wash | ingt | on I | 3lvd. | , El | kridge | e, Md. | 212 | 227 |
| | 20e. METHOD OF DISPOSIT 1 Buriel 2 Cremete 4 Donation 8 0000 | n d I Rem | novel troop Statu | other | e of dispo place) udon | | | | | | 100 | cation - cm | | |
| | 21. SIGNATURE OF TUNES | | CENSPE | | | 22. G | NAME AI | L. F | ss of fa (auti | nan F | uneral | L Home | | |
| | PART I. Entar the d shock, or h iMMEDIATE CAUSE (Fit disease or condition resulting in daeth) | aart fallure. | complications the List only ons can | et caused tha | daath. Do | | | | | | | | | Approximata Interval Between Onsat and Daeth |
| z | | | Aobe | A H | SEQUENCE | A. | 111/11 | | , , | | | | | |
| CERTIFICATION | Sequentielly list condit if sny, laading to imme cause. Entar UNDERLY | dleta | QUE TO | D IN IA | REQUENCE | | mac | · S | | _ | | | | |
| TE | CAUSE (Disesse or injuthet initiated events resulting in daeth) LAS | | C. DOE 10 | (OR AS A CONS | EQUENCE | OF! JV | .,, | | | | | | | |
| 띩 | | | d | | | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other signific | ent conditio | ns contributing to | daath but no | t resulting | in tha u | ndariyin | g cause | given in | Part i. | PERFOI 1 TYES | RMED? | AM CC DF | ERE AUTOPSY FINDINGS AILABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO |
| Σ | 2 | all | | | | | | | | _ | | | " | - 147 117 |
| CIA | WAS CASE REFERRED | O MEDICAL | HOSPITAL: | | | OTHE | | LACE OF | DEATH (C) | heck only or | 10) | | | |
| ıs | YES 2 THO | | 1 Inpatient 2 | | | | reing Hon | JURY AT | tealdence | 8 Othe | | INJURY OCCUI | RED | |
| BY P | 1 M Natural 5 _ | Pending Investigation | | Day, Year) | | NJURY | W | YES 2 | □ NO | | | | | |
| | a Character | Could not be determined | 28a. PLACE (building | OF INJURY — At, atc. (Specify) | home, farm | , street, fa | ctory, offic | ca . | | | ATION (Street or Town, State | and Number or) | Rural Rout | te Number, |
| City or Town, State) City or Town, State) City or Town, State) City or Town, State) City or Town, State) City or Town, State) City or Town, State) | | | | | | | | nd manner ee stated. | | | | | | |
| TO BE C | 7 | 0 | Deso | DMI | | | | 29c. LIG | ENSE NU | MBER . | 1 | 29d, DATE S | SIGNED (M | onth, Day, Year) |
| F | DAVI D | R | KON 1 | SE OF DEATH (| 40 | WE | SD | 经 | 219 | 3 | MINH | e C | lo | UNIA- |
| | NOV 3 | 90 | 1 | Jan's SIGNATUR | 1. | 82 | M | | | | | | | |

7



| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death, Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache fine within 72 hours after death with the State Deut, of Health and Mental Hyglene prior to burial, cremation, or removal, | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|--|--|
|---|--|--|

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - FOR STATE REGISTRAR | TATE OF MARYL | | MENT OF H | | MENTAL HYGIENE | | |
|--|---|-------------------------|---------------------|-----------------------------|---|-------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) James | J | etz | | | 2. DATE OF DEATH MONTH DAY | YEAR Q.O | 3. TIME OF DEATH |
| | | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | | HPLACE (State or Foreign |
| 10.14 | M 2 □ F | | ONTHS DAYS | HOURS MIN. | (Month, Day, Year) Z - / 2 - 3 | Coun | try) |
| 9a. FACILITY NAME (If not institution, give atreet | and number) | - | 9b. CITY, TOWN C | R LOCATION OF DE | | 9c. COUNTY OF | |
| Bon Secours Hospi | tal | | Baltin | ore City | , | N/A | |
| RESIDENCE OF DECEDENT | | | | | | | |
| 10e. STATE 10b. COUNTY | | | TOWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| Md. N/A | | Dal | timore | | | | 1 X YES 2 NO |
| the state of the s | 1.4. | | 101 | ZIP CODE | | | WHAT COUNTRY? |
| 404 S. Smallwood S | | NIII O ADMED | | 21223 | 10.001010101010111111111111111111111111 | US. | |
| 1 Naver Married 2 Married | WAS DECEDENT EVER I FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, sp | | IC ORIGIN? (Specify Yea n, Puarto Rican, atc.) | Spe | E — American Indien, ck, White, etc. |
| 3 Widowed 4 X Divorced | | | | - Office | | | white |
| 15. DECEDENT'S EDUCATION (Specify only highest grade comp | ON pleted) | 18a. DECEDENT'S U | SUAL OCCUPATION No. | IN at of working | 16b. KIND OF BUSI | NESS/INDUSTRY | |
| | ollege (1-4 or 5+) | Iffe. Do NOT use | rearea.) | | | | |
| 9 | | Truck | Driver | | Transp | ortatio | n |
| 17. FATHER'S NAME (First, Middle, Last) | | | | The second of the second of | ME (First, Middle, Maiden S | Sumame) | |
| Henry J. Getz | | | | | e Landon | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 100 | | | Route Number, City or Town | | |
| Henry J. Getz | | | | | Balto., M | | |
| 20a. METHOD OF DISPOSITION 1 1 1 | from Stata | other place) | | | | ATION — City or 1 | L. C. Calendario |
| 4 Donation 5 Other (Specify) | | Western S | | | | timore, | Md. |
| 21, SIGNATURE OF HURERAL SERVICE LICENS | 1 | | Gary | L. Kauin | an Funeral | Homes | |
| Lary d | . Louf | nen | 5695 | Main Str | reet, Elkri | dge, Md | . 21227 |
| 23. PART I. Enter the disease, or com | | | ot enter the mo | de of dying, sucl | h es cerdiec or respir | etory erreet, | Approximete |
| shock, or heert bulure. Liet IMMEDIATE CAUSE (Final | | | | | | | interval Between Onset and Deeth |
| disease or condition resulting in deeth) | DISSEM MI | a consequence of | Intrava | scular | lougulo p | utty | |
| | Pneum | unin | | | | | [|
| Sequentielly list conditions, if any, leeding to immediate | DUE TO (OR AS | A CONSEQUENCE OF | | • | | | |
| cause. Enter UNDERLYING | Liver | Failur A CONSEQUENCE OF | e wi | th Asc | ites | | |
| CAUSE (Disease or injury thet initieted events | DUE TO (OR AS | CONSEQUENCE OF | : | • | | | |
| resulting in death) LAST | Dver w | helming | Sep | 5 13 | | | |
| PART II. Other aignificant conditions of | ontributing to death | out not resulting in | the underlyin | cauee given in | Part i. 24a. WAS AN | AUTOPSY 24 | b. WERE AUTOPSY FINDINGS |
| | | • | , | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | 1 YES 2 | MI NO | OF DEATH? 1 ☐ YES 254 NO |
| | | | | | | | 1 YES 2014 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 28 Pi | ACE OF DEATH (Ch | eck only one) | | |
| EXAMINER? | OSPITAL: | | OTHER: | | | | |
| 27, MANNER OF DEATH | 28a. DATE OF INJURY | 28b. TIME | | | 6 ☐ Other (Specify) 28d. DESCRIBE HOW II | IJURY OCCURED | |
| 1 Netural 5 Pending | (Month, Day, Year) | INJU | JRY WO | PRK? YES 2 NO | | | |
| 2 Accident Investigation 3 Suicide & Could not be | 28a. PLACE OF INJUR | Y — At home, farm, a | | | 261. LOCATION (Street a | nd Number or Rura | I Route Number, |
| 4 Homicide 8 Could not be | building, atc. (Spe | ocity) | | | City or Town, State) | | |
| 29e. CERTIFIER 1 CERTIFYING PHYSICIAI | Y: To the heat of my know | vledge death occurre | d at the time date | and place, and due | to the rever(e) and man | ner se stated | |
| (Check only one) 2 MEDICAL EXAMINER: C | - 6 | | | | | | (a) and manner as stated, |
| | | - Alexander | | | | | |
| 296. SIGNATURE AND TITLE OF CERTIFIER | Ш. п | 11. | | D 2 9 A | | 290. DATE SIGNE | D (Month, Day, Year) |
| 30. NAME AND ADDRESS OF TEASON WHO C | OMPLETED CAUSE OF D | EATH (IT WAY) (Type | Print) | V389 | 45 | - 1117 | 15/40 |
| Lerren Oldern | | | Hunou | W ST | Balt N | nD 21 | 230 |
| 31, DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE Pandell | | | 2-12 | | |
| 1100 0 0 00 | $\perp a$ | | | | | | |

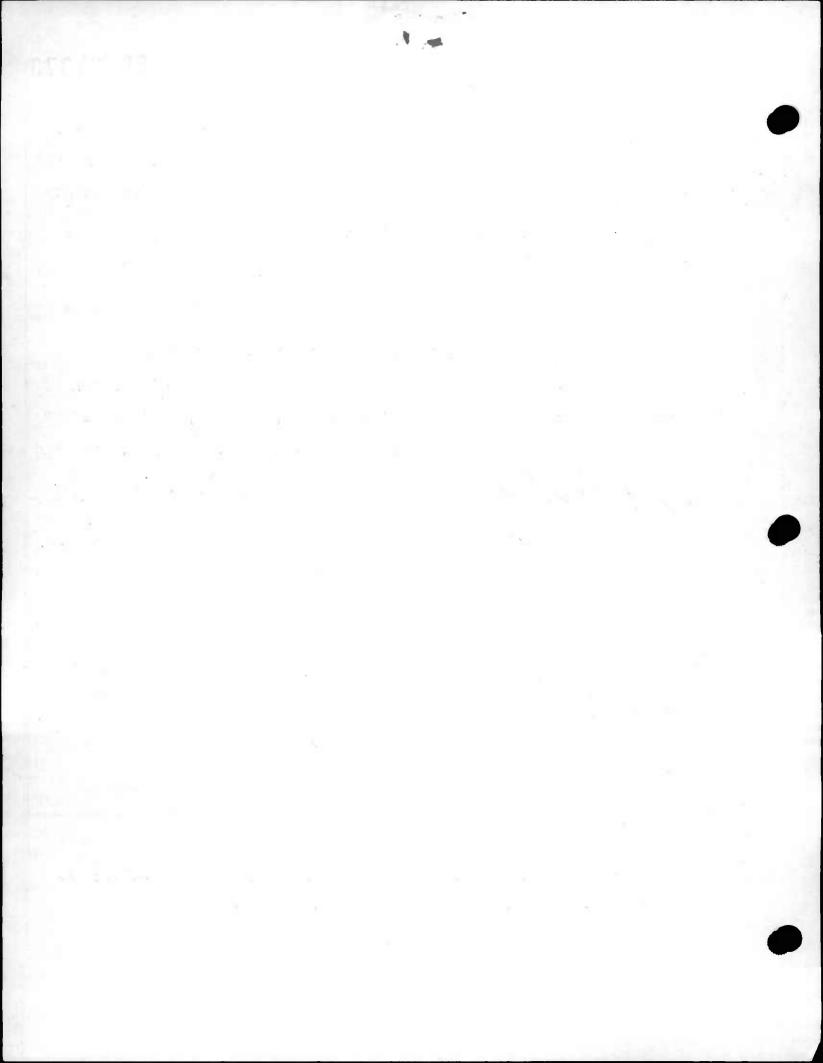
TO BE COMPLETED BY FUNERAL DIRECTOR

| ise as th | | |
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| by the | and Mer | / Injur |
| signed | Health a | ws an |
| s been | ept. of | 3 sho |
| icate ha | State D | Item 2 |
| is certif | ith the | ed, or |
| After th | death w | mark |
| ECTOR: | s affer | n 28 is |
| ML DIR | 72 hour | If Item |
| FUNER | Within | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| TO THE | be filed | IMPOF |
| | TO THE FUNEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal. |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTA | L HYGIENE |
|--|-----------|
| CERTIFICATE OF DEATH | REG. NO. |

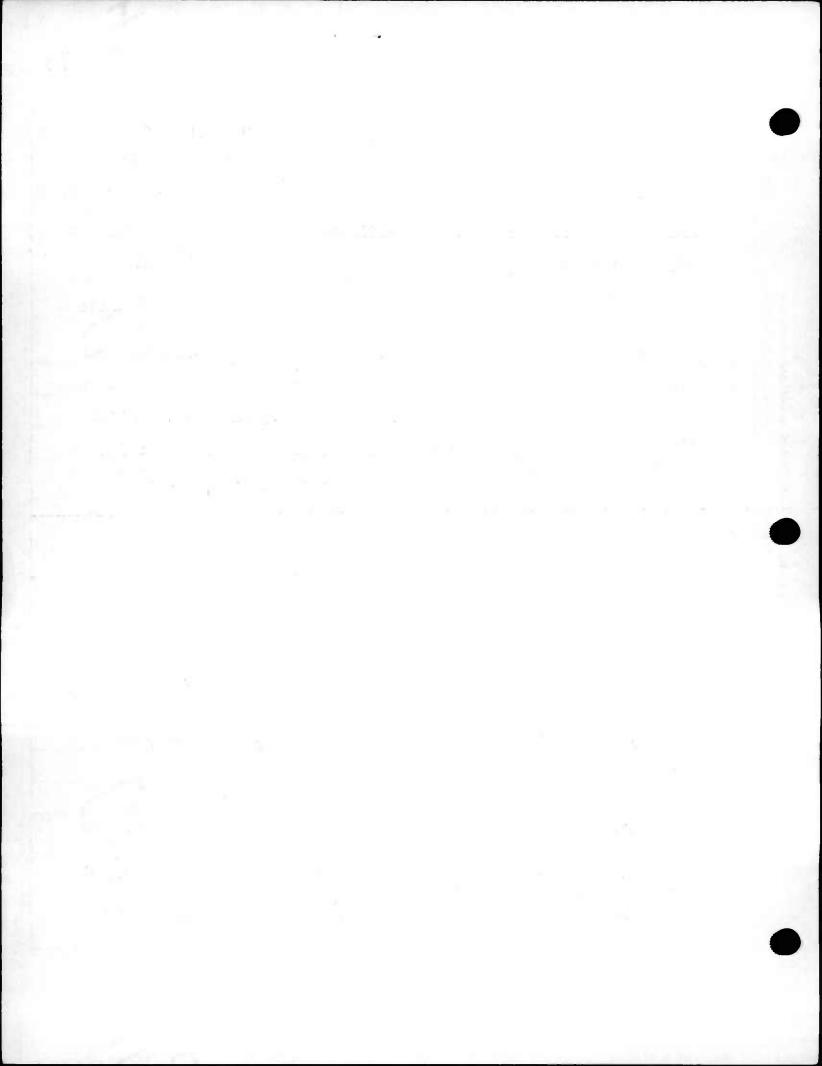
| 1 - FOR STATE REGISTRAR | | STATE OF MARYL | AND / DEPARTI | | | MENTAL HYGIEN | E | |
|--|--|---|-------------------------|--------------------|----------------------|---|-----------------|--|
| 1. DECEDENT'S NAME (First, | INT'S NAME (First, Middle, Last) JENNINGS FAIRFAX GAITHER | | | | | | 90 Y | 3. TIME OF DEATH 5 1.5p M |
| 4. SOCIAL SECURITY NUMBER | | | | F UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 6. | BIRTHPLACE (State or Foreign Country) |
| 216-03-059 | • | | 82 YRS. M | DAYS DAYS | HOURS MIN. | 01-12- | 1902 | Maryland |
| 9a. FACILITY NAME (If not ins | | and number) | 9 | | OR LOCATION OF DE | ATH | 9c. COUNTY | |
| 12501 Rout | te 216 | | | Hig | hland | | How | vard County |
| 10e. STATE | 10b. COUNTY | | | OWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | Ho | ward Coun | ty Hi | ghlan | d | | 3.0 | 1 TYES 2 NO |
| 10e. STREET AND NUMBER | - 016 | | | 101 | 20777 | | - | N OF WHAT COUNTRY? |
| 12501 Rou | | . WAS DECEDENT EVER I | 1110 10100 | 1 | | | | |
| 1 Never Married 2 X 3 Widowed 4 Divor | Merried | FORCES? 1 YES | 2 NO | If yes, sp | | IC ORIGIN? (Specify Year, Puarto Rican, atc.) | or No- 14 | RACE — American Indian, Black, White, etc. Specify: White |
| 15. DECE (Specify only | DENT'S EDUCATI | ION npleted) | 16a. DECEDENT'S US | k done durina ma | ON ost of working | 16b. KIND OF BUS | SINESS/INDUS | |
| Elementary/Secondary (0- | | College (1-4 or 5 +) | life. Do NOT use n | etired.) | | t. Gen | aral | Motors |
| 8th | riciim I p.not | | TEXTEGI (| er/ra | | | | MOTOLS |
| | 1 | ay Gaithe | r | | | ME (First, Middle, Meiden inia | , | hardson |
| 19a. INFORMANT'S NAME (Ty | | ay dar one | | ODRESS (Street I | | Oute Number, City or Tow | | |
| Audrey Ig | lehart | Gaither | | | | | | land 20777 |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation | | from Ctoto | o. PLACE OF DISPOSITI | ION (Name of cer | metery, crematory or | 20c. LO | | y or Town, State |
| 4 Donation 5 Other | (Specify) | 15 | altimore | -Wash | ington | Crem. | Laure | el, Maryland |
| 21. SIGNATURE OF FUNERAL | SERVOCE LICENS | SEE IN . | | 22. NAME AI | ND ADDRESS OF FA | Slack | Funer | al Home |
| 1/1 | Mar | 1/L | M00535 | 5 | Ellicot | t City. | Maryl | and 21043 |
| 29. PORT I. Enter the dis | eeses, or com | plicatione that cause | d tha death. Do not | | | | | t, Approximate |
| IMMEDIATE CAUSE (Fin | | t only one couse on e | | | | | | intarval Between Onset and Death |
| disease or condition resulting in death) | → | arterios | dutie | hear | + dies | n | | Ser years |
| | | | CONSEQUENCE OF): | | | | | |
| Sequentielly list condition | ons, b | DHE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| If any, leading to immed cause. Enter UNDERLYII | | DUE TO (OR AS A | CONSEQUENCE OF ;: | | | | | |
| CAUSE (Disease or Injur | у С. | DUE TO (OR AS | CONSEQUENCE OF): | | | | | |
| resulting in death) LAST | d | | | | | | | |
| PART II. Other significan | nt conditions o | antribution to death i | out not requiting in | the underbile | a anna abaa la | Part i. 24s, WAS AN | ALTONO V | 24b. WERE AUTOPSY FINDINGS |
| Central ant | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 11-7- 2 | . 1 | | | - Male | econom | 1 🗆 YES 2 | NO | OF DEATH? |
| # 02 - | G. L. | udiae an | est, rem | neut u | min | - | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO | MEDICAL | | | 26. PI | LACE OF DEATH (Chi | ock only one) | | |
| EXAMINER? 1 YES 2 NO | | OSPITAL: | | THER: | ne 5 Rasidence | | | |
| 27. MANNER OF DEATH | | 26e. DATE OF INJURY | 26b. TIME C | OF 26c. INJ | JURY AT | 26d. DESCRIBE HOW I | NJURY OCCUP | RED |
| | Pending nvestigation | (Month, Day, Year) | RULNI | | YES 2 NO | | | |
| 3 Suicide 6 0 | Could not be letermined | 26a. PLACE OF INJURY building, etc. (Spe | / At home, farm, stre | et, factory, offic | ca . | 26t, LOCATION (Street City or Town, State) | | Rural Route Number, |
| | FYING PHYSICIA | N: To the best of my know | riedge, deeth occurred | at the time, date | and place, end due | to the cause(a) and ma | nner as stated. | |
| | | | | | | | | cause(a) and menner as stated. |
| SIGNATURE AND TITLE | OF CERTIFIER | | 0 | | 29c. LICENSE NUM | IBER | 29d. DATE S | HGNED (Month, Day, Year) |
| Dwale | 1. O. | illa hu | | | D138 | 32 | 1 | 23 NW 90 |
| 30. NAME AND ADDRESS OF Donald | PERSON WHO C | ompleted cause of de lon, MD | ATH (ITEM 27) (Type, Pr | | n// | 7 4 | | |
| | | | | Olne | y, Mary | Tand | | |
| 31. DATE FILED (Month, Day, 1 | 190 | 32. REGISTRAR'S SIGN | IATURE 100 | | | | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



| | STATE OF MARYLAND / DEPARTMENT OF HEALTH AND | MENTAL HYGIENE |
|-----------------|--|----------------|
| | CERTIFICATE OF DEATH | REG. NO. |
| Miciclio I net) | | |

| 1 - STATE REGISTRAR | STATE OF MARYLAND / | DEPARTMENT (| | MENTAL HYGIE | | |
|--|--|--|---|---|----------------------|--|
| 1. DECEDENT'S NAME (First, Mich Harry D | | | | 2. DATE OF DEATH MONTH | | ZEAR 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 212-30-5361 9a. FACILITY NAME (If not institute | 5. SEX 6. AGE (In yrs. les | YRS. MONTHS D | AYS HOURS MIN. | 7. DATE OF BIRTH | 1932 | BIRTHPLACE (State or Foreign Country) Naryland |
| | lis Road | | altimore | EATH | | imore Count |
| Maryland | Baltimore Co. | Balti | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 100. STREET AND NUMBER 4452 Annapo | | | 10f. ZIP CODE 21227 | | 10g. CITIZE | N OF WHAT COUNTRY? |
| 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U.S. AR FORCES? 1 YES XXXIII IF YES, GIVE WAR OR DATES | MiQ If ye | B DECENDENT OF HISPAI DES, specify Cuben, Mexico YES 2 NO Specifi | n, Puerto Rican, etc.) | Yes or No 14 | I. RACE — American Indian, Black, White, atc. Specify: White |
| 15. DECEDEN (Specify only high Elementary/Secondary (0-12) 5th. 17. FATHER'S NAME (First, Middle, Value of the control of the | est grade completed) (G iffe. | CEDENT'S USUAL OCCU live kind of work done duri . Do NOT use retired.) | JPATION ng most of working | | BUSINESS/INDUS | bution |
| 17. FATHER'S NAME (First, Middle, WOODPOW | | Lacher | 18. MOTHER'S NA | ME (First, Middle, Maid | | |
| 19a. INFORMANT'S NAME (Type/Pa Sharon L. G. | int) 19 | 4 52 Anna | treet and Number or Rural polis Rd. | Aoute Number, City or 1 | fown, State, Zip Co | Canapp (D) 21227 |
| 20a METHOD OF DISPOSITION 2 Durial 2 Cremation 3 4 Donation 5 Other (Spec | Removal from State 20b. PLACE other place of the place of | OF DISPOSITION (Name | of cemetery, crematory or | 20c. | LOCATION — CIT | |
| 21. SIGNATURE OF FUNERAL SES | . /./ | 53.5 | Ellicot | Slac | k Fune | ral Home and 21043 |
| immediate Cause (Final disease or condition resulting in death) | es, o complications that caused the defailure. List only one cause on each line a. Cardio pu DUE TO (OR AS A CONSECT | | | | apiretory arrea | t, Approximate Interval Betwee Onset and Deat |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OP AS A CONSE | QUENCE OF): | er you | m Ton | gue_ | |
| PART II. Other significant co | enditions contributing to death but not r | esuiting in the under | riying cause given in | | AN AUTOPSY ORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEI EXAMINERY 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pendi 2 Accident Invest | HOSPITAL: | OTHER: | 26. PLACE OF DEATH (Ch | eck only one) | 41 | |
| 1 YES 2 D NO 27. MANNER OF DEATH 1 Netural 5 Pendi | 1 Inpetient 2 ER/Outpetient 3 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF 189 | Home 5 Residence c. INJURY AT WORK? | 8 Other (Specify) 28d. DESCRIBE HOV | HOS P | |
| | gation 28e. PLACE OF INJURY — Al ho building, etc. (Specify) | | YES 2 NO | 281. LOCATION (Stree City or Town, Sta | et and Number or | Rural Route Number, |
| | G PHYSICIAN: To the best of my knowledge, de EXAMINER: On the basic of examination and/or (| | | | | |
| 296. SIGNATURE AND TITLE OF C | 2 Atleaunch; | mD | 29c, LICENSE NUI | | | IGNED (Month, Pay, Year) |
| | WHO COMPLETED CAUSE OF DEATH (ITER ECCOCK UNIV. O | FMD HOS | spital,: | ZZ Souti | h Gree | me st. |
| 31. DATE FILED (Month, Day, Year) | 32, REGISTRAR'S SIGNATURE | nds 82 | - u | | | |



| DALIMONE, N |) THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-10urs after death. Page 6 may be | I THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page to the state of |
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| DIVISION OF VITAL RECORDS, F.O. BOA 13149, | . OR | PIO |
| | MAK | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the |
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Dr. S.

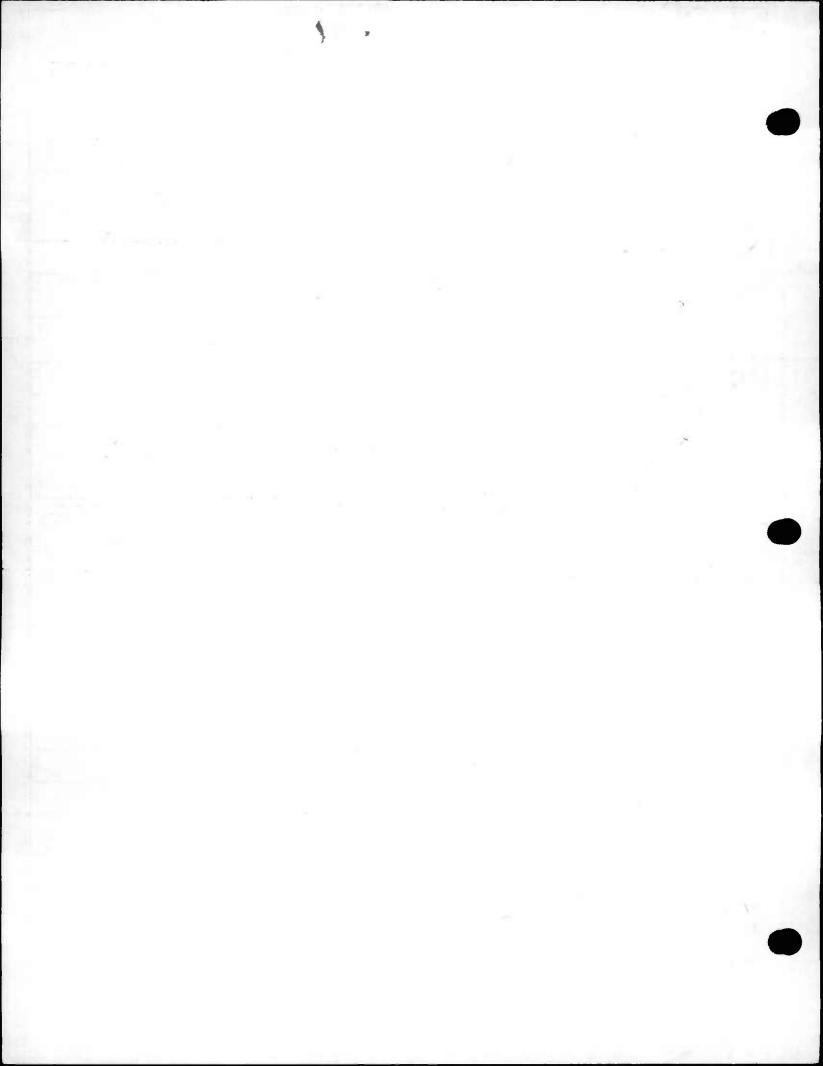
31. PATE FILED (MOUNT), DOWN
DEC 0 7 1990

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Sandhir

| | REGISTRAR 1. DECEDENT'S NAME (First, Middle, I | Last) | - OLII | THIOAT | L OF | DEATH | | REG. NO. | | 3. | TIME OF DE |
|---------------------------|---|---|--|---|--|--|--|---|--|-------------------------|--|
| | Elva R. Gardne | r | | | | | MON | | | YEAR 90 | 8.30 |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX / 6. AG | E (In yrs. last birti | | R 1 YEAR | IF UNDER 24 HR | . Z. DAT | E OF BIRTH | | . BIRTHPLA | |
| | 212 24 1071 | 1 🗆 M 2 💢 F | 64 Y | RS. MONTHS | DAYS | HOURS MIN | . 04 | th, Day, Year) | 26 | Country) | 1 |
| _ | 9e. FACILITY NAME (If not institution, | | | 9b. CIT | Y, TOWN O | R LOCATION OF | | | | Y OF DEATI | |
| 6 | 23 Charlestown | | | onac | oning. | Md | | Δ11 | egany | | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. CO | | 10 | c. CITY, TOWN | | | | | | | INPLOT OF |
| 뜸 | Md A11 | egany | | onacor | - | | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | egarry | | JOI M. O. | | ZIP CODE | | | 10a, CITIZE | EN OF WHAT | , |
| FUNERAL | 23 Charl | estown St. | | | 2 | 1539 | | | | SA | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EVE | R IN U.S. ARMED | 13 | WAS DEC | ENDENT OF HIS | PANIC ORIG | IN? (Specify Yes | | 4. RACE — | American In |
| BY F | 1 Never Married 2 Married | FORCES? 1 YE | | | If yes, spe | cify Cyrben, Me: | dcan, Puerto | Rican, etc.) | | Black, WI | olte, etc. |
| | 3 Widowed 4 Divorced | | | | | 7 | | | | M. M. | hite |
| COMPLETED | 15. DECEDENT'S (Specify only highest | | (Give ki | ENT'S USUAL (| during mos | N st of working | 16 | b. KIND OF BUS | SINESS/INDUS | STRY | |
| Ž | Elementary/Secondary (0-12) | College (1-4 or 5+) | | VOT use retired. | | | | | | | |
| N N | 11 17. FATHER'S NAME (First, Middle, Last | 0 | <u>I Shirt</u> | Facto | ry | | | Clothir | | | <u></u> |
| | | <u></u> | | | | | | Middle, Maiden | Sumame) | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | Richardson | [m | MAILING ACCRESS (Street and Number or Rural Route N | | | | De Vault | | | |
| 2 | | | | | | | | | | iode) | |
| | James F. McKen: | | 20b. PLACE OF D | | | Lonaco | | | | | |
| | 1 Buriel 2 Cremation 3 : 4 Donation 5 : Other (Specify) | Removal from State | other place) | | | , | | | CATION — CI | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | E LICENSEE | | Oak H1 | NAME AN | emetery | FACILITY | Ll.on | aconir | ng, Md | |
| | · 1 | m.V. | | | | nhorn-M | | ie Fun | eral E | Tome | |
| | Many V | Maple | | | Lona | aconino | Md | 21539 | | | |
| | 23. PART I. Enter the diseases, | or complications that causure. List only one ceuse on | sed the daeth. | Do not coto | | | | | | | A |
| | snock, or neert talk | nier rier outh oute cense of | each line. | DO HOE SHES | r tha mod | de of dying, a | uch as ca | rdiac or respi | iratory arres | st, | Approxi |
| | IMMEDIATE CAUSE (Final | | each lina. | | | | | | | | intarval |
| | snock, or neert fall | a. Ca | AyCin | ma | | | | | | 1201 | Interval Onset a |
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| CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initisted events resulting in death) LAST | b DUE TO (OR AS | S A CONSEQUEN S A CONSEQUEN | ICE OF): | • | Brei | nst | | | 1201 | Onset a |
| O | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events | b DUE TO (OR AS | S A CONSEQUEN S A CONSEQUEN | ICE OF): | • | Brei | nst | nuttr | AUTOPSY | la Sta | Onset and Onset |
| O | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b DUE TO (OR AS | S A CONSEQUEN S A CONSEQUEN | ICE OF): | • | Brei | nst | rulta | AUTOPSY- IMED? | 24b, WEI | Interval Onset al Ons |
| O | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a | S A CONSEQUEN S A CONSEQUEN | ICE OF): | • | Brei | nst | 24s. WAS AN PERFOR | AUTOPSY- IMED? | 24b. WEI | Interval Onset al Ons |
| MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a | S A CONSEQUEN S A CONSEQUEN | ICE OF): | • | Brei | nst | 24s. WAS AN PERFOR | AUTOPSY- IMED? | 24b. WEI | Interval Onset al Ons |
| MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other significant cond | a | S A CONSEQUEN S A CONSEQUEN | ICE OF): CE OF): ting in the u | ndertying | Brei | in Part i. | 24a. WAS AN PERFOR | AUTOPSY- IMED? | 24b. WEI | Interval Onset al Ons |
| MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST | a | S A CONSEQUEN S A CONSEQUEN S A CONSEQUEN Dut not resul | ICE OF): CE OF): ting in the u | nderlying 26. PL | J cause given | in Part i. | 24a. WAS AN PERFOR | AUTOPSY- IMED? | 24b. WEI | Interval Onset al Ons |
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| D BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other aignificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 3 Suicide 6 Could not | a | S A CONSEQUEN S A CONSEQUEN S A CONSEQUEN Dut not resul | ICE OF): CE OF): CE OF): ting in the u | nderlying 26. PL R: raing Home 28c. INJL WITT | Cause given ACE OF DEATH 5 TResident NOT NOT NOT NOT NOT NOT NOT NO | in Part I. Check only one 8 - Other 28d. De | 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY-IMED? NO NJURY OCCUI | 24b. WE AMA CON OF 1 | Interval Onset at the Conset a |
| D BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAEXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigate 1 | a | S A CONSEQUEN S A CONSEQUEN S A CONSEQUEN Dut not resul | ICE OF): CE OF): CE OF): ting in the u | nderlying 26. PL R: raing Home 28c. INJL WITT | Cause given ACE OF DEATH 5 TResident NOT NOT NOT NOT NOT NOT NOT NO | in Part I. Check only one 8 - Other 28d. De | 24a. WAS AN PERFOR 1 YES 2 | AUTOPSY-IMED? NO NJURY OCCUI | 24b. WE AMA CON OF 1 | Interval Onset at the Conset a |
| D BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigat 2 Accident 3 Suicide 6 Could not determine | a | S A CONSEQUEN S A CONSEQUEN S A CONSEQUEN Dut not resul | CE OF): CE OF): CE OF): ting in the u OA A Nu D. TIME OF INJURY M | 26. PL: R: raing Home 28c. INJL WO' 1 Y ttory, office | ACE OF DEATH TAKE TAKE NO NO | In Part I. Check only of the 8 □ Oth 28d. De Ch | 24a. WAS AN PERFOR 1 YES 2 or (Specify) ESCRIBE HOW II CATION (Street at or Town, State) | AUTOPSY IMED? NO NJURY OCCUP and Number or | 24b. WEI AMA COO OF 1 C | Interval Onset at the Conset a |
| BY PHYSICIAN: MEDICAL C | IMMEDIATE CAUSE (Final disease or condition resulting in desth) Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST PART II. Other algnificant cond 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine 29c. CERTIFIER (Check only) | a | S A CONSEQUEN S A CONSEQUEN S A CONSEQUEN Duty not result utpatient 3 D Y 28t BY At home, 9 pocify) owledge, death o | CE OF): CE OF): CE OF): CE OF): Ting in the u OA A Nu D. TIME OF INJURY M arm, street, fac | 26. PL: R: raing Home 28c. INJL WO' 1 Y ttory, office | ACE OF DEATH TAKE TAKE TO NO TO N | In Part I. Check only of the St. LO. Ch. | 24a. WAS AN PERFOR 1 YES 2 To YES 2 CATION (Street at or Nown, State) | AUTOPSY IMED? NO NJURY OCCUI | 24b. WEI AMA COO OF 1 [| Interval Onset a Supervision of the Autopsy Labels Prior Prior Transfer of the Autopsy Labels Prior Prior Transfer of the Autopsy Labels Prior Prior Transfer of the Autopsy Labels Prior Transfer o |

ndhir 48 Tarn Terrace, Frostburg, Md 21532

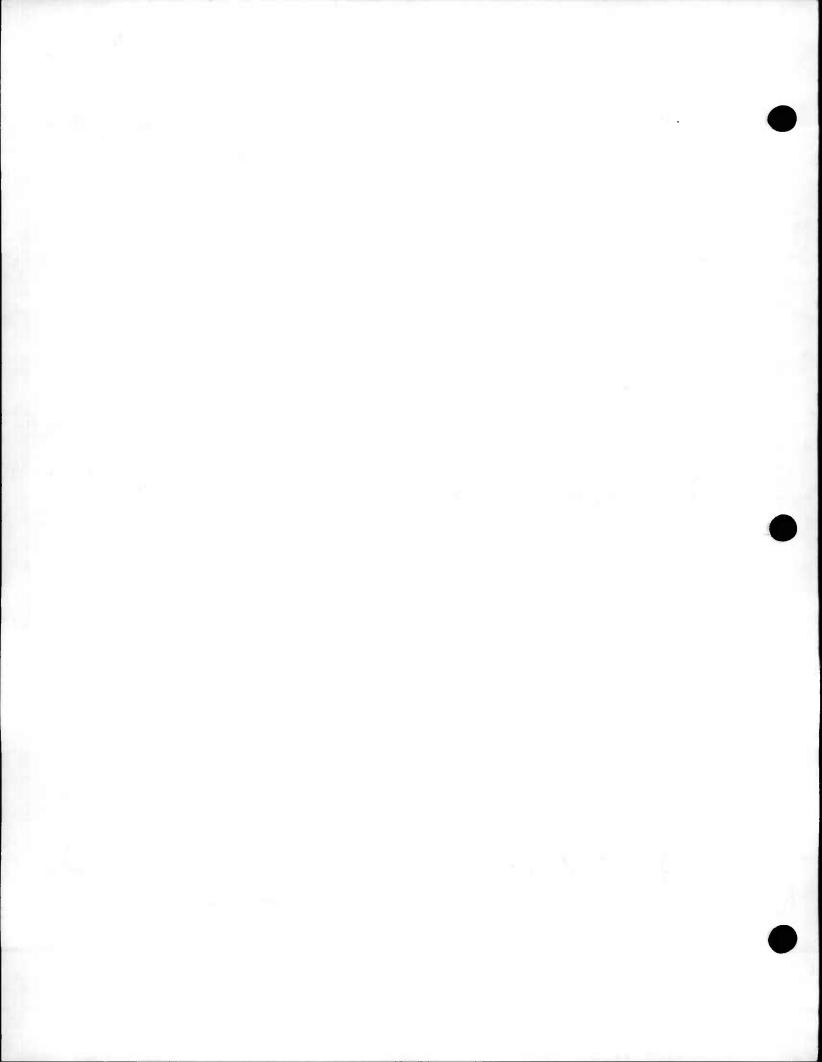


TO BE COMPLETED BY FUNERAL DIRECTOR

| e rospital di attending prigordani. | ector, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | | nce |
|--|---|---|--|
| IN INV. SEQUENCES THAT THE DESCRIPTION OF EMPERON WITHIN 22 HOURS STEEL DOCUMES THAT SECURITIES BY THE INSPIRED OF STEELINGS | nis certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be det | f Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT; It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at on |
| THE HOSPITAL OR ALLENDING PHYSICIAN. THE IAM IS | TO THE FUNERAL DIRECTOR: After this certificate has bee | be filed within 72 hours after death with the State Dept. o | IMPORTANT; It item 28 is marked, or item 23 sh |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYLAND / | | MENT OF | | MENTAL HYGIEN | _ | | |
|---|--|-------------------|-----------------------------|--|---|--|-------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | Grane | | | | 2. DATE OF OEATH | | EAR 3. T | ME OF DEATH HE A M |
| | 5. SEX 6. AGE (In yrs. les | | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3-23-08 | e (State or Foreign | | |
| 98. FACILITY NAME (If not institution, give street 921 Baucher Lane | et and number) | | 9b. CITY, TOWN | OR LOCATION OF OR | EATH | 9c. COUNTY OF OEATH Anne Arundel | | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CITY. | TOWN OR LOCA | | | | 10d | INSIDE CITY |
| | nce George | | urel . | 1.04 | | La ciria | 1 2 | YES 2 NO |
| 919 Montgomery Str | eet | | | 20707 | | USA | OF WHAT | COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | RMEO NO | If yes, s | | NIC ORIGIN? (Specify Ya nn, Puarto Ricen, atc.) y: | | - 14. RACE — American Indian, Black, White, etc. Specify: Caucasian | | |
| 15. DECEDENT'S EDUCA (Specify only highest grade or Elamentary/Secondary (0-12) | College (1-4 or 5+) | | | | 166. KIND OF BU | | TRY | |
| 17. FATHER'S NAME (First, Middle, Last) Maurice Waskey | | | | | ME (First, Middle, Meider Hartman | Surname) | | |
| 190. INFORMANT'S NAME (Type/Print) Roland E. Grauel | | | ADDRESS (Street aucher | | napolis, M | | | J |
| 2%METHOD OF OISPOSITION 1 Burial 2 Cremation 3 Ramov 4 Donation 5 Other (Specify) | al from State St. Par | OF OISPOS | Luthera | n church | Cemetery | Fulto | | |
| PC SIGNATURE OF FUNERAL SERVICE LICE | | \ | 22. NAME / | AND ADDRESS OF FA | AL INI | Funera | 1 Hom | e, Inc. 20707 |
| 23. PART i. Enter the disesses, or co | emplications that caused the delet only one cause on each line | | ot entar tha m | oda of dying, suc | h as cardiac or resp | lretory arrest | t, | Approximete interval Between |
| iMMEDIATE CAUSE (Finsi disease or condition resulting in death) | aplasti | `< | | mia | | | | Oneat and Death |
| | DUE TO (OR AS A CONSE | OUENCE OF |): | | | | | |
| Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSE | OUENCE OF |): | | | | | |
| CAUSE (Disesse or injury that initiated events resulting in death) LAST | DUE TO (OR AS A CONSE | OUENCE OF |): | | | | | |
| PART ii. Other significant conditions | contributing to deeth but not | resulting is | n the underlyi | ng cause given in | | | | RE AUTOPSY FINDINGS |
| | | | | | 1 YES | RMEO? | COL | ILABLE PRIOR TO MPLETION OF CAUSE DEATH? |
| | | | | | | | 1 [| YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. | PLACE OF OEATH (C) | heck only one) | | | |
| | 1 Inpatient 2 ER/Outpatient : | _ | 4 - Nursing Ho | | 6 Other (Specify) | | | |
| 1 Natural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 26b. TIME | URY | IJURY AT YORK? YES 2 NO | 28d. DEŞCRIBE HOW | INJURY OCCUI | RED | |
| 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY — At he building, etc. (Specify) | ome, farm, a | treet, factory, of | ice | 28f. LOCATION (Stree City or Town, State | | Rural Route | Number, |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, dete end place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. | | | | | | | | |
| 296. SIGNATURE AND THE OF CERTIFIER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 297. LICENSE NUMBER 297. LICENSE NUMBER | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO H.D. GOLDSTE. | | EM 27) (Type, 2 0 | Print) 5 12I | DGELY | AVE | AI | NA | PUCIS |
| 31. DATE FILED (Month, Day, Year) NOV 2 7 '90 | 32. REGISTRAR'S SIGNATURE Sulia Davidson-Rand | Lelle | | | | | | |



DHMH-18 Rev 1/89

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY FUNERAL DIRECTOR

| CERTIFICATION |
|---------------|
| MEDICAL |
| BY PHYSICIAN: |
| LETED BY |
| SE COMPI |
| 10 E |

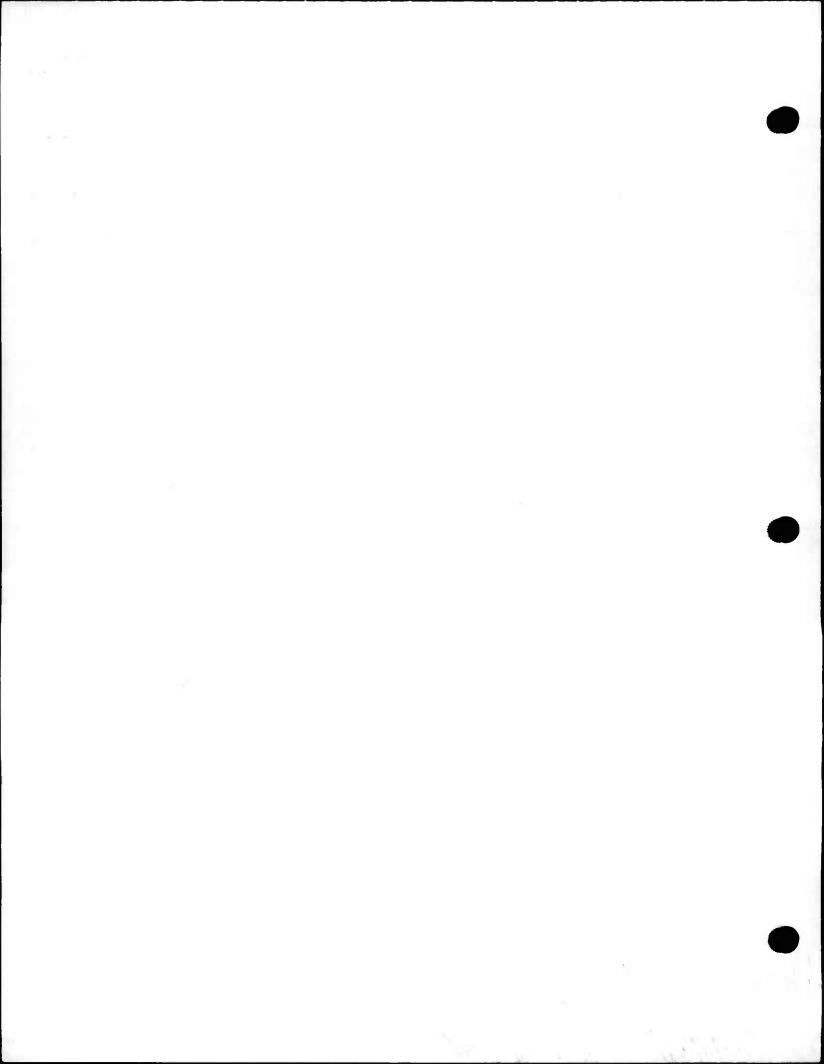
| FOR | STATE OF M | ARVI AND A | DEDAR | rment. | UE NE | AITU | AND I | MENTAL U | VCIEN | | 9 | 0 3437 |
|--|--|--|---------------------------------|------------------|-----------------------|-----------|----------------------------------|--|---------------------------|-------------|--------------|--|
| 1 - STATE REGISTRAR | SIAIL OF M | | ERTIFI | | | | | | EG. NO. | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. OATE OF E | EATH DA | v | YEAR | 3. TIME OF DEATH |
| | obert | GLAS | GOW | | | | | Novem | | | | 4:35 A.M. |
| 4. SOCIAL SECURITY NUMBER 216-58-9369 | 5. SEX 1X M 2 F | 6. AGE (In yrs. Ia. | | IF UNDER 1 | - | IF UNDER | 24 HRS. MIN. | 7. DATE OF B | 3, 1 | 951 | 6. BIRTH | PLACE (State or Foreign |
| 9a. FACILITY NAME (If not institution, give st | reet and number) | | | 9b. CITY, 1 | TOWN OR | LOCATIO | ON OF DE | <u> </u> | | 9c. CO | UNTY OF C | DEATH |
| Doctors' Commun | ity Hospi | tal | | La | nhan | n | | | | Prin | ice G | Georges 1 |
| RESIDENCE OF DECEDENT 10a, STATE 10b, COUNTY | | | 100 CITY | TOWN OR | LOCATIO | | | | | | | |
| Maryland Princ | e George | ¹s | | per N | | | • | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| 10a. STREET AND NUMBER | ъ . | | | | 10f. 2 | ZIP CODE | | | | | | WHAT COUNTRY? |
| 134 Old Enterpris | | | | | | | 2077 | | | | S.A. | |
| 11. MARITAL STATUS 1 Never Merried 2 Married 3 Wildowed 4 X Divorced | 12. WAS DECEOENT FORCES? 1 [IF YES, GIVE WA | EVER IN U.S. AI YES 2 X R OR DATES | RMED NO | 13. W | AS DECEI yes, spec | NDENT O | F HISPAN n, Maxica Specify | IIC ORIGIN? (Sp n, Puarto Rican y: | ecify Yea , atc.) | or No— | Spec | E — American Indian, k, Whita, atc. ify: Casian |
| 15. DECEDENT'S EDUC (Specify only highest grade | | 16a. DI | ECEDENT'S I | JSUAL OCC | CUPATION | of workin | | 16b. KIN | D OF BUS | SINESS/IN | DUSTRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | | live kind of w b. Do NOT use | | | O WOTAIN | 9 | | | | | |
| 12th | | m | eat c | utter | • | | | So | oldie | rs h | ome | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | HER'S NA | ME (First, Middle | , Malden | Sumame) | | |
| William Earl Glasg | ow | | | | | Cas | ssie | Delore | s E | cker | d | |
| 19a. INFORMANT'S NAME (Type/Print) | | 19 | b. MAILING | ADDRESS (| Street and | d Number | or Rural I | Route Number, C | ity or Town | n, State, Z | ip Code) | _ |
| Cassie D. Glasgov | N | | | | | | | I., Up | per | Marl | boro | , Md. 2077: |
| 20a. METHOO OF DISPOSITION 1 Burlal 2 Commission 3 Ramo 4 Donation 5 Onne (poorly) | oval trying State | a sedio | of oispos opolit | | | | | | | | city or To | wn, State Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | 7/3 | 10/10 | Sha | ₋ 473 | 39 B | alt. | Av | CH'S S | SON | S Fl | JNEF , Ma | RAL HOME aryland |
| 23. PART I. Enter the diseeses, or c shock, or heart fallure. I | omplications that | ceused the de | eath. Do n | ot enter t | he mod | e of dyl | ng, euc | h es cerdiac | or respi | ratory e | rreet, | Approximate |
| IMMEDIATE CAUSE (Finel disease or condition | 17 | amor | | C | ell | 1 | 10 | mel. | n | 19 | | interval Betwaan Onaet and Daeth |
| resulting in daath) | | | | | | | | | | | | |
| | 600 /h | Pulle | 18824 | re | | 11/0 | (9) | Ras, | 5 | , | | |
| Sequentially list conditions, if any, leading to immediate | DUE TO (| OR AS A CONSE | OUENCE OF |): | | | | | | | | |
| cause. Enter UNDERLYING CAUSE (Diseese or injury | (and | no D. | Am | nar | 4 | 0 | Pry | rest | - | | | |
| that initiated events | DUE TO (| OR AS A CONSE | OUENCE OF |): / | | | | | | | | |
| resulting in death) LAST | . (on V | W(Z) 0 | 15 | | | | | | | | | |
| PART ii. Other algnificant condition | a contributing to | leath but not | regulting is | n.the und | lerlylna | C91100 C | aluna in | Part i na | MAR AN | AUTOPSY | | D. WERE AUTOPSY FINDINGS |
| Chome Then | al fa | lure | | alie | | Ou ! | ho: | Part 1. 248 | PERFOR | | 240 | AVAILABLE PRIOR TO |
| Gistine team | | 10-07- | | anna | | CAL | 1100 | 0 - 10 | YES 2 | NO | | OF DEATH? |
| | | | | | | de | ucy. | 700 | | | | 1 YES 2 NO |
| | | | | | | | | | | | | A7-17 |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | | CE OF D | EATH (Ch | eck only one) | | | | |
| 1 YES 2 NO | 1/3 Inpetient 2 🗆 | | _ | 4 🗆 Nursir | ng Home | | aldanca | 6 Other (Sp | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF I (Month, Da | NJURY v, Year) | 28b. TIMI INJI | | WOR 1 YE | |] NO | 28d. OEŞCRIE | BE HOW I | NJURY O | CCUREO | |
| 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF building, a | INJURY — At hete. (Specify) | ome, farm, s | treet, factor | ry, offica | | | 26f. LOCATIO City or To | N (Street e wn, State) | and Numb | er or Rural | Route Number, |
| 29a. CERTIFIER 1 CERTIFYING PHYSIC | CIAN: To the best of s | ny knowledge, d | eath occurre | d at the tim | 10, deta a | nd place | , and dua | to the cause/s |) and mar | ta aa renr | ated. | |
| | | | | | | | | | | | | a) and manner as stated. |
| 29b, SIGNATURE AND TUTLE OF CERTIFIER | | | | | | | ENSE NUI | | | | | (Month, Day, Year) |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

Rishpal Singh, M.D. 7525 Greenway Center Drive, #313, Greenbelt,

Sulia Sairdson-Randalle



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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours a | ICOAL DIDECTOR: After this certificate has been signed by the offending absolute and completely filled in the |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

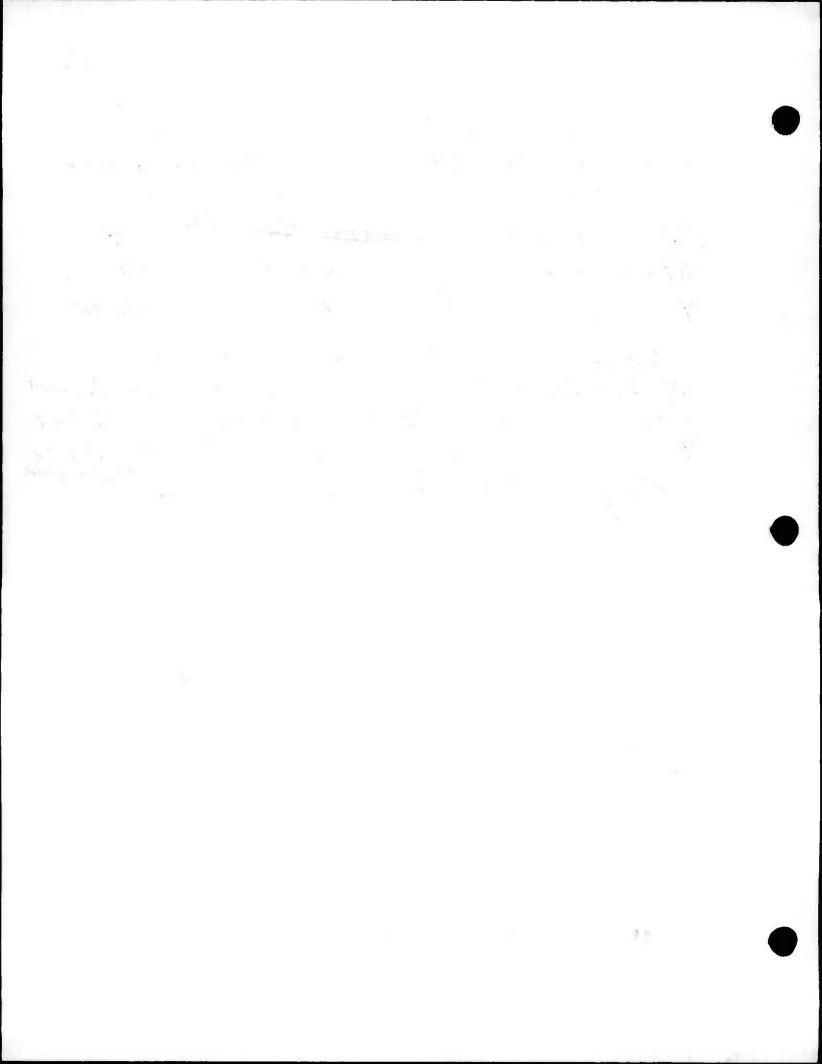
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 29 Mours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNEAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

| 1 - STATE REGISTRAR | STATE OF MARYLAND / DEPAR CERTIF | RTMENT OF HEALTH AND | MENTA | AL HYGIENE REG. NO. | |
|--|--|---|--------------|--|---|
| 1. DECEDENT'S NAME (First g Middle, Last) | M. | GLOVER | 2. DAT | | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 318-20-7024 | 5. SEX 6. AGE (In yrs. last birthday) 1 M 2 F P PRS. | IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN. | (Mon | E OF BIRTH with, Day, Year) 30 1931 | BIRTHPLACE (State or Foreign Country) MARYLAND |
| 90. FACILITY NAME (If not institution, give str Peninsula General | | 9b. CITY, TOWN OR LOCATION OF | DEATH | | Y OF DEATH |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | Salisbury, M | 1D | | Wicomico |
| MD. Som | erset Ci | THE TOWN OF EDUCATION | 10 | N MD. | 10d. INSIDE CITY LIMITS? 1 Yes 2 \(\square\) NO |
| 100. STREET AND NUMBER RH BOX 20 | 6 | 2/83 | 8 | IOg. CITIZE | EN OF WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATE | 13. WAS DECENDENT OF HISP If yea, specify Juben, Mex 1 YES 2 NO Spe | ican, Puerto | IN? (Specify Yes or No— 1- Rican, etc.) | 4. RACE — American Indien, Black, White, etc. Specify: |
| 3 Widowed 4 Divorced 15. DECEDENT'S EDUC | ATION 16s. DECEDENT'S | B USUAL OCCUPATION | | b. KIND OF BUSINESS/INDUS | WHITE |
| (Specify only highest grade of Elementary/Secondary (0-12) | College (1-4 or 5+) (Give kind of life. Do NOT u. | work done during most of working | 1 | Domestic | |
| 17. FATHER'S NAME (First, Middle, Last) | 1 | | NAME (First, | Middle, Maiden Sumame) | |
| 19a, INSORMANT'S NAME (Type/Print) | ORGAN 196 MAILING | ADDRESS (Street and Number or Run | EU BOUTO AND | LA MURG | -AN NELSON |
| CHARLUTTE | GLOVER 75 | RICHARDEO | 1 / | VE. CRISTI | ELD.MD. 31817 |
| 20e_METHOD OF DISPOSITION Suriel 2 | val from State 20b. PLACE OF DISPO | SITION (Name of cemetery, cremetory of | or | 1 | ty or Town, Slate |
| 21. SIGNATURE OF FUNERAL SERVICE LICE | Steeling St. | 22. NAME AND ADDRESS OF | 7 | and then | CRISFIE P, MI |
| IMMEDIATE CAUSE (Final | omplications that caused the death. Do not not only one cause on each line. SQ V & R Look DUE TO (OR AS A CONSEQUENCE O | I stage em | | | at, Approximsta Interval Batween Onset and Daath |
| Sequentially list conditions, if any, lasding to immediate csuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events | DUE TO (OR AS A CONSEQUENCE O | | | | |
| resulting in dasth) LAST | | | | | |
| PART II. Other significant conditions | contributing to death but not resulting | In the underlying cause given | in Part I. | 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIDR TO COMPLETION DF CAUSE |
| | | | | 1 TYES 2 NO | OF DEATH? |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | 26. PLACE OF DEATH (| Check only o | ne) | |
| and the same of th | HOSPITAL: 11 inpatient 2 ER/Outpatient 3 DOA | OTHER: 4 □ Nursing Home 5 □ Residence | _ | | |
| 1 Natural 5 Pending 2 Accident investigation | 28e. DATE OF INJURY (Month, Day, Year) 28b. TIM | IE OF 28c, INJURY AT WORK? M 1 YES 2 NO | 28d. DE | SCRIBE HOW INJURY OCCU | RED |
| 3 Suicide 6 Could not be 4 Homicide determined | 26a. PLACE OF INJURY — All home, farm, building, etc. (Specify) | street, factory, office | 28f. LO | CATION (Street and Number or rown, State) | Rural Route Number, |
| | IAN: To the best of my knowledge, death occurr | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | On the basic of examination end/or investigation | 29c. LICENSE N | | | GIGNED (Month, Day, Year) |
| Contin 7. | Dallon | 031 | 546 | > // | 1/28/90 |
| Igrahus L | COMPLETED CAUSE OF DEATH (ITEM 27) (Type) | | r 6 | Ko friece | on sup is |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | 90 | | | 2185 |



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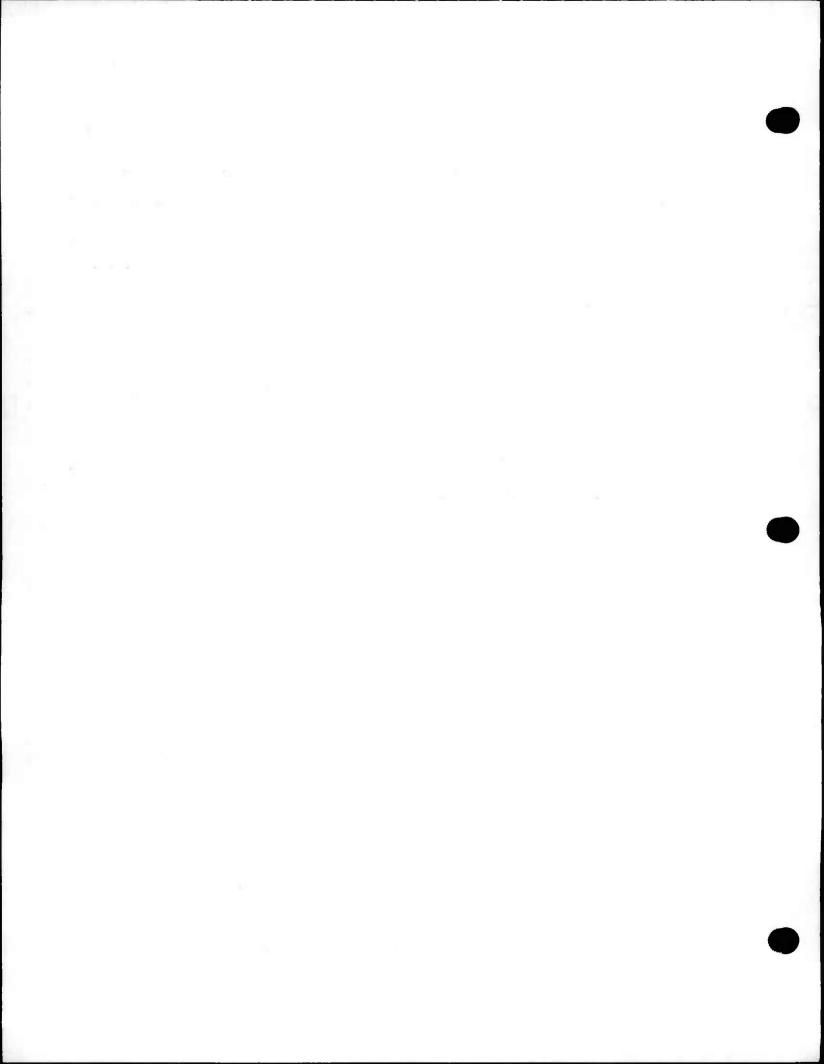
REG. NO

DIRECTOR Maryland Prince George's Upper Marlboro 10e. STREET AND NUMBER FUNERAL 10f. ZIP CODE 807 Falcon Drive 20772 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO 1 Never Merried 2 Married IF YES, GIVE WAR OR DATES BY 3 XWidowed 4 Olvorced COMPLETED 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done du life. Do NOT use retired.) Secondary (0-12) College (1-4 or 5+) N/A 6th Fireman 17. FATHER'S NAME (First, Middle, Last) Walter Edward Gardner BE 19a. INFORMANT'S NAME (Type/Print) 2 Mary Lou Downs Same as 10 A-F 2 20a. METHOD OF DISPOSITION
1 ☐ Burlel 2 🛱 Cremetion 3 ☐ Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or Lee Crematory 4 Donetion 5 Other (Specify) 21. BIGNATURE OF FUNERAL SERVICE LICENSEE euanno IMMEDIATE CAUSE (Final e diseese or condition resulting in death) OUE TO (OR AS A CONSEQUENCE OF): CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): If any, leeding to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): that initieted events resulting in death) LAST PART II. Other aignificent conditions contributing to deeth but not reaulting in the underlying ceuse given in Part i. MEDICAL PHYSICIAN: 33 25. WAS CASE REFERRED TO MEDICAL **EXAMINER?** HOSPITAL:
1 12 Inpatient 2 | ER/Outpatient 3 | DOA OTHER: 1 YES 2 NO 4 🗌 Nu 0 certi HOSPITAL DR ATTENDING PHYSICIA 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF INJURY · this c 28c. INJURY AT WORK? marked, 1 Natural 5 Pending м DIRECTOR: After the hours after death w 1 YES 2 NO BY Investigation 2 Accident 28s. PLACE OF INJURY — At home, farm, street, lactory, offica building, atc. (Specify) 3 Suicide LETED a Could not be 4 Homicida 29e, CERTIFIER COMPL TO THE HOSPITAL C TO THE FUNERAL D be filed within 72 ho 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER wh BE 024283 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 2 · YUSUF 3450 Fout meade 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE

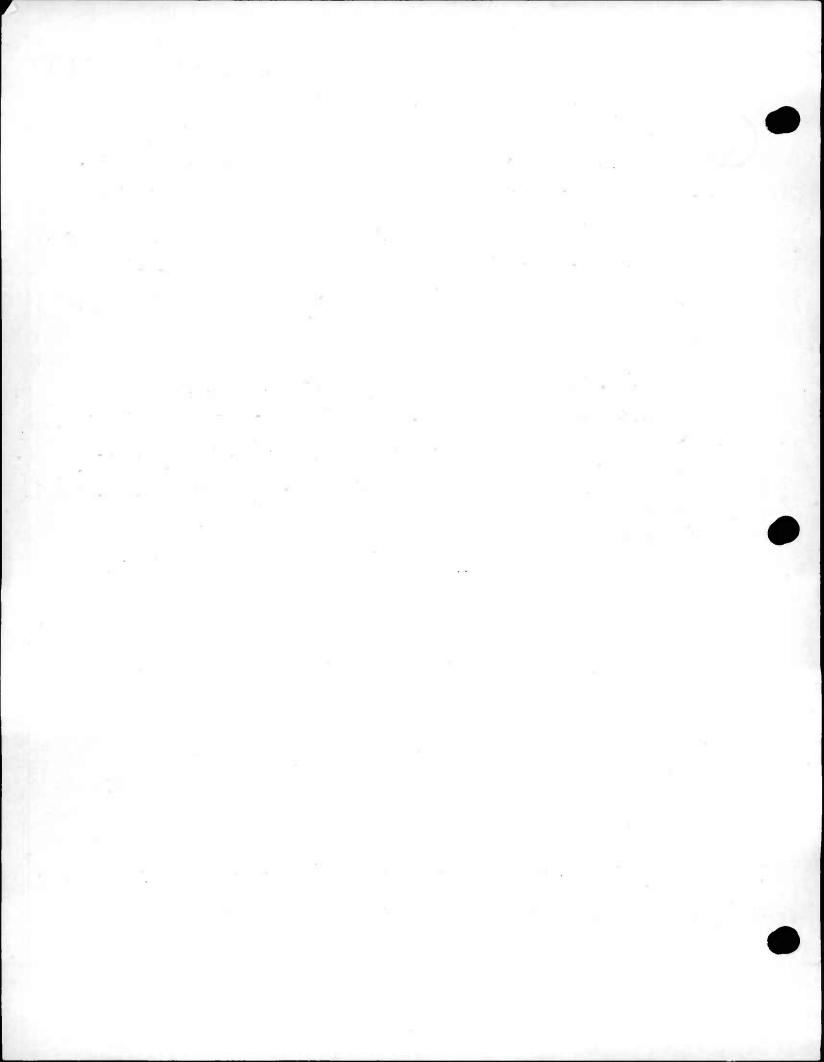
· Davidson-Randelle

1. DECEOENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH 3. TIME OF DEATH YEAR 1990 Loyd Edward GARDNER 11 24 5:50P 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) a, BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS 464-03-2977 77 1XXM 2 □ F YRS. Pain OK 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH Doctors Hospital Lanham Prince George's 10a. STATE 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? 1 - YES 2 NO 10g. CITIZEN OF WHAT COUNTRY? U.S.A. 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Mexicen, Puerto Rican, atc.)

1 ☐ YES 2 ☒ NO Specify: Specify: Caucasian 18b. KING OF BUSINESS/INQUSTRY Government Service 18. MOTHER'S NAME (First, Middle, Maiden Sumame) Bernice Sessum 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. LOCATION - City or Town, State Clinton, Maryland 22. NAME AND ADDRESS OF FACILITY Lee Funeral home, Inc. 6633 Old Alexander Ferry Rd Clinton, Md20735 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximata Intervel Batween Acute Myscandial infunction **Onset end Daath** 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE 1 🗌 YES 2 🔀 NO OF DEATH? 1 YES 2 NO 26. PLACE OF OEATH (Check only one) ing Home 5 - Residence 6 - Other (Specify) 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1 CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the time, date and piece, and due to the cause(a) and menner ea stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29d. DATE SIGNEO (Month, Day, Year) 11.25.98 Lamel



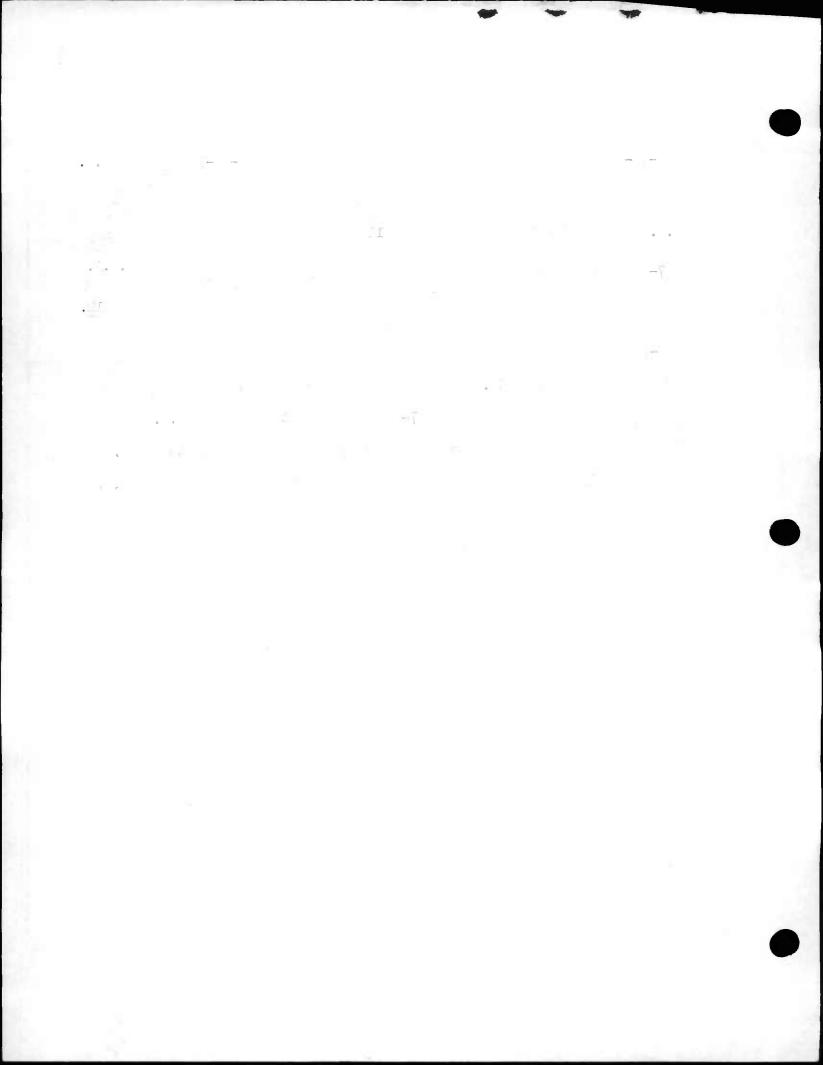
| disease or condition resulting in death) PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions contributing to death but, not resulting in the underlying ceuse given in Part I. PART II. Other significent conditions. PART II. Other significent conditions. PART II. Other significent conditions. PART II. Other significent conditions. PART II. Other significent conditions. PART II. Other significent conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant conditions. PART II. Other significant condit | | REGISTRAR | | LAND / DEPARTM CERTIFIC | | | REG. NO. | | |
|--|---------------------------------------|--|--|--|---|--|--|--------------------------------------|---|
| TOO BEAST RO. Apt. 201 Salisbury Solisbury | 1 | Laura Har | per | | | | | | TIME OF DEATH |
| The strict of the strict of | 1 | 229-09-7186 | 1 🗆 M 2 💢 F | 6 YRS. MOI | NTHS DAYS | HOURS MIN. | (Month, Day, Year) -19-1914 | Country) | Va. |
| 10. S TREET AND NAMEER 10. ON B Bast Rd. Apt. 201 10. S TREET AND NAMEER 10. ON B Bast Rd. Apt. 201 11. MANIFAL STATUS 11. MANIFAL STATUS 11. MANIFAL STATUS 11. MANIFAL STATUS 12. WAS DECEMBENT STATUS 11. WAS DECEMBENT OF HISRANC CRIGINAL (Speechly Vis or No. 14. Black, white, set. only 10 yes 2 yes or no consistence of the set. | OH. | 1008 East Rd | . Apt. 201 | 96 | | | | | |
| Too Seast Rd. Apt. 201 10, STEET Rd. NO NAIMER 10 OS East Rd. Apt. 201 11, MANTAL STATUS 12, Was DECEMENT EVER IN U.S. AME NO PROPERTY 12, Was DECEMENT OF HIBRANC CHROINT (System) Was or No. 16, BECCEPT 17 YES 2 No 17 YES 2 No 19 YES, GAVE WAR OR DATE 17 YES 2 No 19 YES, GAVE WAR OR DATE 19 Y | HEC | 10e. STATE 10b. COU | INTY | | OWN OR LOCATIO | DN | | | LIMITS? |
| Specify Specify Specify Specify Specify Specify Black Specify Specif | | 10e. STREET AND NUMBER | | Sal | 106 | ZID CODE | | CITIZEN OF WHA | |
| 16. DECEDENT'S EDUCATION [Class Bad of working] Elementary@seconday (0-12) 17. PATHER'S NAME (First, Middle, Last) JOSEPH L. Bayne 18. MOTHER'S NAME (First, Middle, Last) JOSEPH L. Bayne 19. INFORMANT'S NAME (First, Middle, Last) JOSEPH R. Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne 19. INFORMANT'S NAME (First, Middle, Maloben Surneme) Florence Bayne Florence Bayne Florence Bayne Florence Bayne 10. Information or Name Florent Number, or Name Fl | | 11. MARITAL STATUS 1 Never Merried 2 Merried | 12. WAS DECEDENT EVER FORCES? 1 YES | 3 2 NO | If yes, spec | Ify Cuben, Mexicen, Pr | ORIGIN? (Specify Yee or No- | 14. RACE — Black, V | American Indian White, etc. |
| Tigo. INFORMANT'S NAME (Type/Print) The INFORMANT'S NAME (Type/Print) Robert Harper Rt. 2 Box 456 Salis. M. 21801 20b. PLACE OF DISPOSITION (Name of cameles), crematory or dispuls but minted. City or Town, State. 20 Code) 20c. METHOD OF DISPOSITION (Them of cameles), crematory or dispuls of the place of the pla | 1 | (Specify only highest gr Elementary/Secondary (0-12) | ade completed) | (Give kind of work life. Do NOT use re | done during most tired.) | | | | 31.001 |
| Robert Harper Rt.2 Box 456 Salis. Md. 21801 20c. DESPOSITION Name of cemetry, crematory or 20c. LOCATION - City or Town, Sista 1 Buster 2 Ceremetron 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetry, crematory or 20c. LOCATION - City or Town, Sista 1 Buster 2 Ceremetron 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetry, crematory or 20c. LOCATION - City or Town, Sista 20c. DISPOSITION (Name of cemetry, crematory or 20c. LOCATION - City or Town, Sista 20c. LOCATION - City or Town, Sista 20c. DISPOSITION (Name of cemetry, crematory or 20c. LOCATION - City or Town, Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista 20c. LOCATION - Sista | 2 | Joseph L. Ba | yne | 10h MARING AD | | Florenc | e Bayne | | |
| 21. SIGNATURE OF FUNCHAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 23. PART I. Enter the placeses, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or reapiratory erreet, shock, or heart feliure. List only one cause on each line. 14. PART II. Other significent conditions contributing to death but, not resulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. WAS CASE REFERRED TO MEDICAL EXAMINER? 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF INJURY AT WAS PLACE OF INJURY OF PRINTING AND INJURY O | 2 | | er | | ox 456 | Salis. | Md. 2180 | 1 | |
| PART II. Other significent conditions contributing to death but not reculting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PREFORMED? 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 28. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 29. PLACE OF DEATH (Check only one) 29. PLACE OF INJURY 29. INJURY 2 | RTIFICATION | immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. DUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): | et | Failu | Ne | | Onset and |
| EXAMINER? Sext and the second of the seco | | resulting in death) LAST | | | | | | | U |
| Accident investigation M 1 YES 2 NO 28. PLACE OF INJURY — At home, farm, street, factory, office 28. LOCATION (Street end Number or Rural Poute Number | MEDICAL CE | PART II. Other significent condit | 1 1 3/1/01 | () | he underlying | ceusa given in Par | PERFORMED? | All Ci | MILABLE PRIOR 1 OMPLETION OF C F DEATH? |
| | SICIAN: MEDICAL CE | PART II. Other significent condit | HOSPITAL: | HUN tipetient 3 000 4 | 26. PLA FHER: □ Nursing Home | CE OF DEATH (Check of | PERFORMED? 1 YES 2 NO only one) Other (Specify) | AN CC OH | MILABLE PRIOR TO OMPLETION OF CA F DEATH? |
| | TED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide 6 Could not 1 determined | HOSPITAL: 1 Inputient 2 ERVOU 28a. DATE OF INJUR (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Sp | tipetient 3 DOA 4 CONTROL TIME OF INJURY IY — At home, farm, stree ecity) | 26. PLA THER: Nursing Home F 28c. INJUI WORI M 1 _ YE t, factory, office | CE OF DEATH (Check of 5 Residence 6 28 28 NO 28 | PERFORMED? 1 YES 2 NO Other (Specify) d. DESCRIBE HOW INJURY (City or Town, State) | OCCURED | MILABLE PRIOR : MPLETION OF CL F DEATH? YES 2 N |
| CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the lime, date end place, end due to the cause(e) end manner se stated. CERTIFYING PHYSICIAN: To the beat of my knowledge, death occurred at the lime, date end place, end due to the cause(s) end menner se at the lime, date end place, end due to the cause(s) end menner se at | TED BY PHYSICIAN: MEDICAL CE | PART II. Other significent conditions of the condition of | HOSPITAL: 1 Inpatient 2 ER/Ou 28a. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp | tipetient 3 DOA 4 2 28b. TIME Of INJURY TY — At home, farm, stree ecily) | 26. PLA THER: Nursing Home F 28c. INJUI WORI M 1 YE It, factory, office | CE OF DEATH (Check of 5 Residence 6 28 28 NO 28 28 28 28 28 28 28 2 | PERFORMED? 1 YES 2 NO Other (Specify) d. DESCRIBE HOW INJURY (City or Town, State) De cause(e) and manner ee | DCCURED | MILABLE PRIOR TO MAPLETION OF C. F DEATH? YES 2 N |
| 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month, Day, Year) | BE COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation of Could not 1 determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER AND TITLE OF CERTIFIER 29b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE 20b. SKIMATURE AND TITLE OF CERTIFIER 20b. SKIMATURE 20b. | HOSPITAL: 1 Inpatient 2 EPVOu 28a. DATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Sp IYSICIAN: To the beat of my kno INNER: On the basis of examinati | tpetient 3 00A 4 (28b. TIME Of INJURY 28b. TIME Of INJURY Wedge, death occurred at the course of t | 28. PLA THER: Nursing Home F 28c. INJUI WORI 1 YE t, factory, office | CE OF DEATH (Check of 5 Residence 6 RY AT 28 RY A | PERFORMED? 1 YES 2 NO Only one) Other (Specify) d. DESCRIBE HOW INJURY (City or Town, State) he cause(e) end manner ee a, dete end plece, end dua to | DCCURED stated. biber or Rural Rou | MILABLE PRIOR TOMPLETION OF CL P DEATH? YES 2 N N te Number, |
| 296. SICHAUHREIAND TITLE OF CERTIFIER 296. DATE SIGNED (Month, Day, Year) | E COMPLETED BY PHYSICIAN: MEDICAL CE | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not determined 29a. CERTIFIER (Check only one) 2 MEDICAL EXAM 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ASDRESS OF PERSON | HOSPITAL: 1 Inpatient 2 ER/Ou 28a. DATE OF INJURY (Month, Dey, Year) 28b. PLACE OF INJURY building, etc. (Sp INSICIAN: To the beat of my known of the beat of examination of ex | Intellent 3 DOA 4 EVEN THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF THE CONTROL OF T | 28. PLA THER: Nursing Home F 28c. INJUI WORI 1 YE t, factory, office | CE OF DEATH (Check of 5 Residence 6 RY AT 28 RY A | PERFORMED? 1 YES 2 NO Only one) Other (Specify) d. DESCRIBE HOW INJURY (City or Town, State) he cause(e) end manner ee a, dete end plece, end dua to | DCCURED stated. biber or Rural Rou | MILABLE PRIOR DMPLETION OF 6 F DEATH? YES 2 |



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| | 1 - FOR STATE REGISTRAR | STATE OF M | IARYLAND / CE | | TMENT | | | | | HYGIEN | E | | • |
|-----------------------|---|-------------------------------|-----------------------------|----------------------------------|-------------|------------------|-------------|-----------|--------------------------------|-------------|----------------|----------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DEATH DA | v v | EAR 3. | TIME OF DEATH |
| - mil N to | LESIEK | | | HIC | KMON | D_ | | | 12 | 90 | | 11:40 A ^M | |
| | 4. SOCIAL SECURITY NUMBER 219-78-3093 | 5. SEX | 6. AGE (In yrs. last | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF (Month, D | av. Ybar) | 8. | BIRTHPL/ Country) | ACE (State or Foreign |
| | | 1 X M 2 □ F | 18 YRS. | | | | | 4-22-72 | | | | | M.D. |
| ~ | 9e. FACILITY NAME (If not institution, give | | | 9b. CITY, TOWN OR LOCATION OF DE | | | | | | | 9c. COUNTY | OF DEAT | тн |
| DIRECTOR | Cornish Street | (woods) | | | | Sali. | sbur | у | | | Wic | comic | CO |
| EC | 10e. STATE 10b. COUNT | • | | 10c. CIT | Y, TOWN C | R LOCATI | ION | | | | | 10 | d. INSIDE CITY |
| | M.D. Wicomico | | | | Salis | bury | 7 | | | | LIMITS' | | |
| AL | 10e. STREET AND NUMBER | | | | | 101. | ZIP CODI | | | | 10g. CITIZEN | | T COUNTRY? |
| 빌 | 907-E BOOTH STR | RET | | | | | 218 | 001 | | 8.1 | | U.S | .A. |
| FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Merried | 12. WAS DECEDENT FORCES? 1 | EVER IN U.S. ARM | AED | 13. | WAS DECE | NDENT O | F HISPAI | NIC ORIGIN? (S | Specify Yes | or No- 14. | RACE - | American Indien, /hite, elc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | | • | | YES TES | 2 NO | Specify | n, Puerlo Rica y: | III, etc.) | | Specify: | |
| | 15. DECEDENT'S EDI | ICATION | I see DEC | Chentie | USUAL O | COLUBATIO | | | | | 1 | | Blk. |
| E | (Specify only highest gred Elementery/Secondary (0-12) | e completed) | (Giv | e kind of a | work done o | during mos | t of worldn | g | 18b. KIND OF BUSINESS/INDUSTRY | | | | |
| 7 | 0-12 | College (1-4 or 5 +) | | NONE | 1 | | | | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTI | HER'S NA | ME (First, Midd | tie Maiden | Sumame) | | |
| BE C | LESTER WAYNE HI(| CKMOND Sr. | | | | | | | ARLEN | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | - | 19b. | MAILING | ADDRESS | (Street an | | | Route Number, | _ | | de) | · |
| 2 | FATHER AND MOTE | TER | 9 | 07- | E Bo | oth | Stre | et | Salis | burv | M.D. | 2180 | 01 |
| | 20ayMETHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Ren | | 20b, PLACE C | F DISPOS | SITION /No | me of com | etery, crem | atory or | | | CATION — City | | |
| | 4 Donation 5 Dther (Specify) | | Cotta | ge C | emet | ery | | | | Wes | tover | Md. | |
| | 21, SIGNATURE OF FUNERAL SERVICE LI | | | | | NAME AN | | | | | | | |
| | Russell Foo | oks | | | F | OOKS | FUN | ERAI | HOME | SAI | ISBURY | [M.] | D. 21801 |
| | 23. PART I. Enter the diseases, or | complications that | caused the dea | th. Do r | | | | | | | | | Approximate |
| 1 | shock, or heart fellure. IMMEDIATE CAUSE (Finel | List only one caus | se on each line. | | | | | 08' 991 | | | | , | Interval Between Oneet end Death |
| | disease or condition | . M. 1 + | inlo oto | - h | | _ | | | | | | | Silver ella Death |
| | a. Multiple stab wounds Oue to (or as a consequence of): | | | | | | | | | | | | |
| Z | Sequentielly list conditions, | | | | | | | | | | | | |
| Ĕ | If any, leading to immediate | DUE TO (| OR AS A CONSEO | UENCE OF | 7: | | | | | | | | |
| 5 | CAUSE (Disease or Injury | C | OR AS A CONSECU | IEMOS OED- | | | | | | | | | |
| Ē | that initiated events resulting in death) LAST | 002 10 (| OH AS A CONSECU | DENCE OF | -): | | | | | | | | i |
| CERTIFICATION | | d | | | | | | | | | | | |
| AL. | PART II. Other significant condition | na contributing to | death but not re | sulting l | n the un | deriying | ceuse g | iven in | Part I. 24 | a. WAS AN | | | FRE AUTOPSY FINDINGS AILABLE PRIOR TO |
| 8 | | | | | | | | | | XYES 2 | | co | OMPLETION OF CAUSE |
| ME | | | | | | | | | " | | | | XYES 2 NO |
| ä | | | | | | | | | _ L | | | | _ |
| BY PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | | ACE OF D | EATH (Ch | eck only one) | | | | |
| YSI | 1 X YES 2 NO | 1 Inpatient 2 | | | 4 🗆 Nurs | | 5 🗆 Re | aldence | 6 X Other (S) | pecify) | scene | | |
| H | 27. MANNER OF DEATH 1 Netural 5 Pending | 28a. DATE OF I | | 28b, TIM INJ | E OF URY | 28c. INJU WOF | IK? | | 28d. DESCRI | BE HOW IN | JURY OCCUR | ED | |
| B | 2 Accident Investigation | 12- | -1-90 | | М | 1 🗌 Y | ES 2 X | NO | | _ | stabbe | _ | |
| 8 | 3 Suicide a Could not be | building, e | INJURY — At home. (Specify) | | | | | | City or To | own, State) | nd Number or | | |
| Ħ. | 29a. CERTIFIER | | | | (for | | | | | | | Libuı | ry, Md. |
| COMPLETED | (Check only 1 CERTIFYING PHYS | ICIAN: To the best of n | | | | | | | | | | | |
| 8 | 2 X MEDICAL EXAMIN | ER: On the basis of ex | amination end/or in | vestigatio | n, in my o | pinion, de | ath occur | ed at the | time, date end | d place, en | d due to the c | euse(e) er | nd menner ee stated. |
| BE | 290 SIGNATURE AND TITLE OF CENTIFIE | A 10 | | | | | 29c. LICE | NSE NUM | ABER | | 29d. DATE SI | GNED (Mo | onth, Day, Year) |
| 5 | Kugne Whe | your | | | | | | OCM | íE | | 12 | 2-2-9 | 90 |
| - 1 | 30. NAME AND ADDRESS OF PERSON WI | | | | | | | | | | | | |
| 2 | Margarita A. Ko | rell, M.D | | 111 | Penn | Str | eet | | Baltin | nore, | MD 21 | 201 | |
| 7 | DEC 0 3 '90 | 32. REGISTRAF | vidson-Ran | | | | | | | | | | |
| | 111 1 1 / / 71 1 | Chilla Da | Wala - Ton- | 1.00 | | | | | | | | | |

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| BALI | death. |
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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mounts after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the jurial-transit permit. Pages 1, 2, 1 mount be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

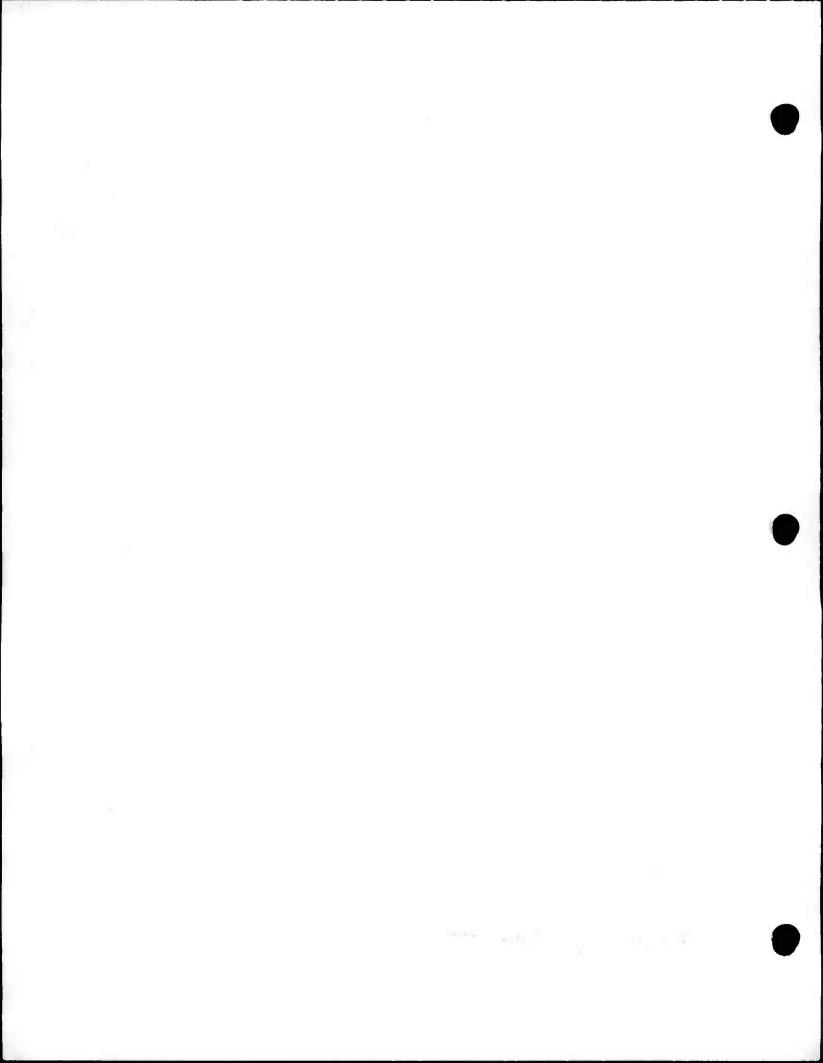
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | 1 - STATE REGISTRAR | STATE OF M | IARYLAND / Ce | DEPAR | TMENT | OF H | EALTH DEAT | AND N | MENT | AL HYGIENI REG. NO. | | 90 | 34382 | | |
|----------------------|--|---|---|--|--|---------------------------|---------------------|---|--------------|--|------------------------------|--|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) BESSIE S. HANCOCK | ζ | | | | | | | 2. DA | TE OF DEATH | 199 | | TIME OF DEATH | | |
|) | 4. SOCIAL SECURITY NUMBER 221-10-6224 | 5. SEX 1 M 2 XF | 6. AGE (In yrs. last | birthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER HOURS | 24 HRS. MIN. | 7. DA (Mc | TE OF BIRTH Onth, Day, Year) 27-1910 | | | ACE (State or Foreign | | |
| NO. | 99. FACILITY NAME (If not institution, give s SALISBURY NÜR RESIDENCE OF DECEDENT | | Ξ | 96. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD. | | | | | | | 9c. COUNTY OF DEATH WICOMICO | | | | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNT | omico | | | Y, TOWN O | | ION | | + | | | - 10 | 0d. INSIDE CITY LIMITS? | | |
| IERAL | 10a STREET AND NUMBER 1514 Riverside I |)rive | | | | 10f | ZIP CODE | | | | USA | ZEN OF WH | AT COUNTRY? | | |
| ВҰ | 11. MARITAL STATUS 1 Naver Married 2 Married 3 Widowed 4 X Divorced | 12. WAS DECEDENT FORCES? 1 IF YES, GIVE W | EVER IN U.S. ARA YES 2000 N AR OR DATES | WED O | 1 1 | f yes, spe | ENDENT OF | ı, Maxicar | ı, Puari | GIN? (Specify Yea o Rican, atc.) | or No— | 14. RACE - Black, V Specify: Whit | - American Indian, White, etc. | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementery/Secondery (0-12) | CATION completed) College (1-4 or 5+ |) (Giv | ve kind of v Do NOT us | usual oc work done of se retired.) | turing mo | IN st of working | g | | 86. KIND OF BUS | | | | | |
| BE CO | 17. FATHER'S NAME (First, Middle, Last) George Franklin 19a. INFORMANT'S NAME (Type/Print) | Sullivan | | | | | Els | ie M | 1. (| t, Middle, Maiden : Collins | Sul1 | | | | |
| 2 | Janet M. Dennis | | | 23 E | rest | on S | St. S | alis | | y, Md. | 2180 | 1 | | | |
| | 1X Burlai 2 Cremation 3 Ram. 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICE | - 12 - 2 - 2 - 2 - 2 | St. S | Cel | iens | Ceme | | | LITY | 1 | Lmar, | De. | , Stata | | |
| | William 33 PART Francis | M. A | lost ? | /_ | Sh | ort O.Bo | Fune | ral 4 De | Hon 1 ms | ne, Inc. ir, De. | 100/ | 0 | | | |
| | Inter- | | | | | | | | | | | | Approximata Interval Batween Onset and Death | | |
| CERTIFICATION | Sequantially list conditions, if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avanta resulting in death) LAST | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated avanta DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other significant condition | a contributing to d | death but not re | sulting i | n tha und | darlying | cause g | Ivan in F | Part I. | 24a. WAS AN A PERFORM 1 YES 2 | MED? | AA CC | ERE AUTOPSY FINDINGS MALABLE PRIOR TO DMPLETION OF CAUSE F DEATH? YES 2 NO | | |
| SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | ER/Outpetlant 3 [| DOA | OTHER Nurs | : | ACE OF DE | | | one) har (Specify) | | | | | |
| ВУ РН | 27. MANNER OF DEATH Natural 5 Pending Accident Investigation | 26a. DATE OF I (Month, Day | | 28b. TIMI | - | 28c. INJL WOF 1 Y | JRY AT | | | ESCRIBE HOW IN | JURY OCC | URED | | | |
| | 3 Suicide 6 Could not be detarmined | INJURY — At hom tc. (Specify) | na, farm, street, factory, offica | | | | | 2et. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | te Number, | | | |
| COMPLETED | 29s. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | CIAN: To the best of n | | | | | | | | | | | nd manner as stated. | | |
| 10 BE | 296. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND ADDRESS OF RESCON WANT | 296. SIGNATURE AND TITLE OF CERTIFIER 10. MAME AND ADDRESS OF REISON WAS COMPLETED DALLS OF DEATH (ITE | | | | | 040190 | | | | | | 29d. DATE SIGNED (Mogth, Day, Year) • (130/90 | | |
| , | 31. DATE PIKED (NOpth, Day, Year) | 2 and | 2,110 | 21) (Npe, | D(14 | bu | py , | hea | ce | ster | IA | lish | iny, Ma | | |
| | DEC U 3 90 | Julia Sai | rs signature Moson—Rono | dell | | | ŧ | | | | | | ' / | | |

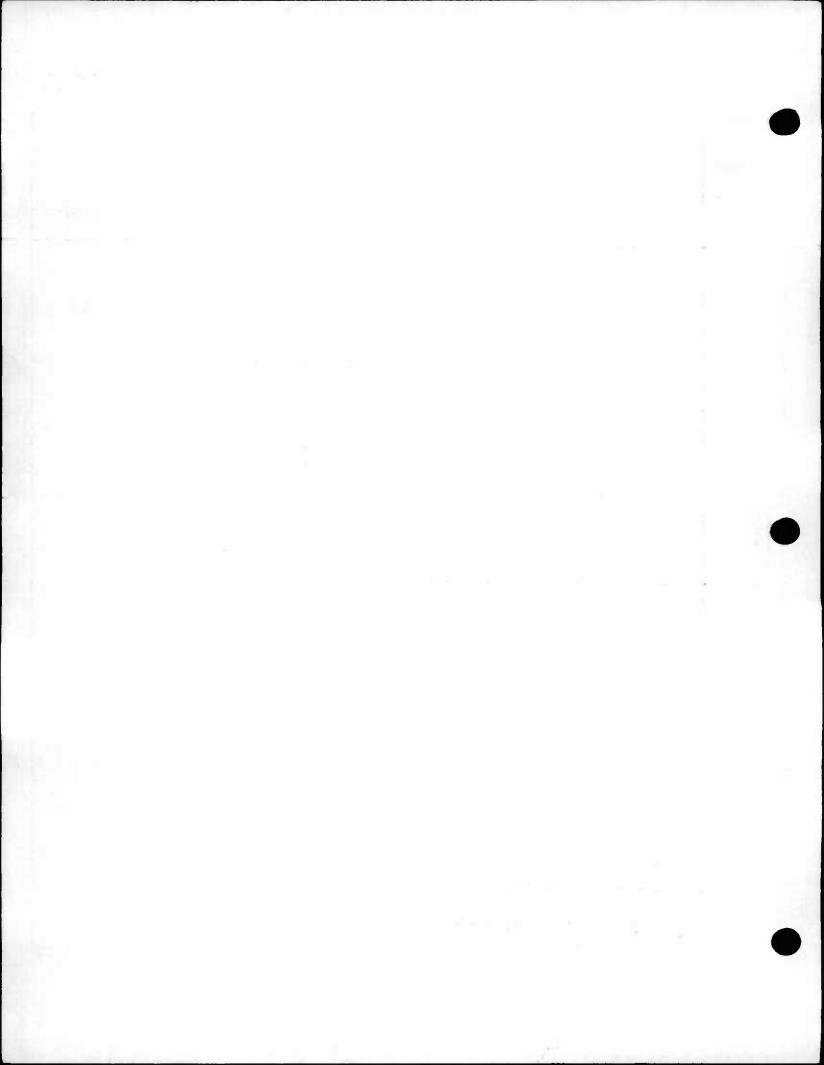
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| and the same | | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPAR | RTMENT OF I | HEALTH AND | MENTAL HYGIENE REG. NO. | 50 | 34383 | | |
|---|--------------|--|--|--------------------------------|------------------------|----------------------|---|--------------------|--|--|--|
| 1 | | 1. DECEDENT'S NAME (First, Middle, Last |) | 4 | | | 2. DATE OF DEATH | | 3. TIME OF DEATH | | |
| | 1) | Janet | Williams | Ham | ilton | | 17/24/9 | YEAR | M | | |
| 1 | | 4. SOCIAL SECURITY NUMBER | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | S. BIRT | HPLACE (State or Foreign | | |
| | | 205-14-7700 | 1 🗆 M 2 👿 F | CE YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) | Coun | try) | | |
| Phoch | | 9a. FACILITY NAME (If not institution, give | street and number) | _65 | 9b, CITY, TOWN | OR LOCATION OF D | L 01/27/25 | 9c. COUNTY OF | | | |
| CO. | E | 1240 2 | • | | | | | | DEATH | | |
| 1, 2, | DIRECTOR | 1340 Argyll Dr | 146 | | Arnol | d | | Anne / | Arundel | | |
| Seg | 1 2 1 | 10a. STATE 10b. COUN | | 10c. CIT | Y, TOWN OR LOCA | TION | | | 10d. INSIDE CITY | | |
| . ⊑ : | | MD Ar | ne Arundel | Aı | cnold | | | | 1 YES 2 NO | | |
| perm | AL. | 10e. STREET AND NUMBER | | | 10 | I. ZIP CODE | | 10g. CITIZEN OF | WHAT COUNTRY? | | |
| physician. bunal-transit permit. Pages | FUNERAL | 1340 Argyll Dr | ive | | | 21 | 012 | U.S.A | A. | | |
| siciar ial-tra | 5 | 11. MARITAL STATUS | 12. WAS OECEDENT EVER I | | 13. WAS OE | CENDENT OF HISPA | NIC ORIGIN? (Specify Year | r No.— 14. RAC | E — American Indian, | | |
| phy pur | | 1 Naver Married 2 Married | FORCES? 1 YES | | | S 2 WHO Specific | en, Puerto Rican, etc.) | Spec | ck, White, alc. | | |
| as the | ВУ | 3 Widowed 4 Divorced | | | | | | 4.00 | White | | |
| afte JSe a | 윤 | 15. DECEDENT'S Ed (Specify only highest grad | UCATION de completed) | 16a. DECEDENT'S | USUAL OCCUPATI | ON not of working | 16b. KINO OF BUSIN | NESS/INDUSTRY | | | |
| for for | | Elamentary/Secondary (0-12) | College (1-4 or 5 +) | ille. Do NOT u | se retired.) | | | | | | |
| iched | δ | | 4 | Homen | naker | | Home | | | | |
| detach once. | COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Maiden St | ırname) | | | |
| d be | w | Edward Leonard | Williams | | | Louis | Pidcock | | | | |
| retained by the hospital or ath 5 should be detached for use notified at once. | 10 B | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAJLING | ADDRESS (Street | | Route Number, City or Town, | State, Zip Code) | | | |
| be re | ١٩١ | Mr. Robert M. | Hamilton . | 1340 | Arovll 1 | Drive | Arnold | B. | 1D 21012 | | |
| nay be | | 20a. METHOD OF OISPOSITION 1 Burial 2 Cremation 3 Res | 200 | other place) | | | | ITION — City or To | | | |
| e 6 ma rector, p | | 4 Donation 5 Other (Specify) | moval from State | Metro Cr | omators | | Coto | sville | MD. | | |
| ral di | | 21. SIGNATURE OF FUNERAL SERVICE Y | CENSEE | | | ND ADDRESS OF FA | | | | | |
| after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the bunial-trar moval. cal examiner must be notified at once. | 1 | > (L(P) | 14 | | Parra | ago Ehrnar | | itchie E | | | |
| n by the removal. | \vdash | 20 54571 | Juna | COT | | | | | ark MD 21146 | | |
| in Pre | | 23. PART I. Entar the diseases, or shock, or heart fallure | complications that cause List only ona cause on e | d the death. Do r ach lina. | not enter the mo | ode of dylng, aud | h aa cardiac or reapira | tory arrest, | Approximata Interval Batwaan | | |
| | | IMMEDIATE CAUSE (Final | 0 1 | 6 6 | \Aa | | 0 | | A 11 | | |
| within 24 npletely fills cremation, vent, the | | disease or condition reaulting in death) | a. Vro Da | 4/5 | MALAO | cavali | at Info | creting | MINUNE | | |
| completely ial, cremati event, t | | | DUE TO (OR AS A | CONSEQUENCE O | F): | | | 1 | , | | |
| executed and com to burial, matic ev | Z | Sequentially list conditions, | | 1 motre | COLY | ER POIL | al Info | LNSERSE | 10- | | |
| ficate be execut physician and cone ne prior to buri | ERTIFICATION | If any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | | | |
| | 2 | cause. Entar UNDERLYING CAUSE (Disease or Injury | C | | | 0 | | | | | |
| n certificate inding physi Hygiene pri or other to | Ë | that initiated eventa resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | | | |
| E E - 6 | E | | d | | | | | | | | |
| Me the | 1 | PART II. Other algnificant condition | na contributing to death b | ut not resulting | in the underlyin | g cause given in | Part I. 24s. WAS AN AL | ITOPSY 244 | . WERE AUTOPSY FINDINGS | | |
| | 5 | | er densi | | | | PERFORM | ED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| signe signe sealth | MEDIC | | | | | | 1 TYES 2 | NO | OF DEATH? | | |
| of t | Σ | | | | | | _ | | 1 TYES 2 NO | | |
| Dept 23 | AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | |
| N: The law requires the cate has been signed State Dept. of Health item 23 shows an | SICIAN: | EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Ch | eck only one) | | | | |
| clan ertific the S | Σ | 1 VES 2 NO | 1 Inpatient 2 ER/Outp | | | | S C Other (Specify) | | | | |
| HYS his c | PHY | 27. MANNER OF DEATH 1 Natural 5 Pending | (Month, Day, Year) | 28b. TIM | | JURY AT DRK? | 26d. DEŞCRIBE HOW INJ | URY OCCUREO | | | |
| NG P | B | 2 Accident Investigation | | | | YES 2 NO | | | | | |
| ENDI PR: A rer d | B | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, atc. (Spec | — At home, farm, a | street, fectory, offic | • | 281. LOCATION (Street and City or Town, State) | Number or Rural | Route Number, | | |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that TO THE FUNERAL DIRECTOR: After this certificate has been signed by be flied within 72 hours after death with the State Dept. of Health an IMPORTANT: If Item 28 Is marked, or Item 23 shows any | | 4 Homicide Omermined | | | | | | | - V | | |
| L Diff | ᅰ | 29a. CERTIFIER 1 CERTIFYING PHYS | SICIAN: To the best of my know | ledge, death occurre | ed at the time, date | and place, and due | to the cause(a) and manne | er an atated. | | | |
| TO THE HOSPITAL TO THE FUNERAL DE filed within 72 IMPORTANT: If | COMF | | ER: On the basis of examination | | | | | | a) and manner as stated. | | |
| HIA WITH | O I | SIGNATURE AND TITLE OF GERTIFIE | | | | 29c. LICENSE NUI | | 9d. DATE SIGNED | | | |
| 로 를 를 | m | Haws Un | en 1 | 0-M | | 0110 | 114 | DATE STONE | 7 1. 190 | | |
| # # # # | 2 | 30- HAME AND ADDRESS OF PERSON W | HO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type | Rrint) | 1) 16 | 10 | , | 0/10 | | |
| | | James Charni | nes mn | 1509 I | Ritchia | 1-/11/ 1 | 1 phone | nol soin | 12 | | |
| 1 | | 31. OATE FILEO (Month, Day, Year) | 32. REGISTRAR'S SIGN | ATURE | 1111110 | 1104.71 | KINULLI | M MO | 10. | | |
|] | | NOV 26 1990 Jul | 32. REGISTRAR'S SIGN | 200 | | , | | | | | |
| - I | | 7 1000 | ., | | | | | | | | |



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| SPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours a | JERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician and completely filled in by the after death with the State Dentr of Health and Mental Hunjane prior to build cremation or sea | 1 |
| 1 | 5 | |
| 03 | = = | E . |

| + 1 | 1. DECEDENT'S NAME (First, Middle, La EVE | rett | | Leon | Ho | csem | an,III | MOI | TE OF DEATH | 90 | YEAR | 3. TIME OF DEATH 8:21PM | |
|---------------------------------------|--|--|---|--|---|------------|---|--|--|--|---|--|--|
| | 4. SOCIAL SECURITY NUMBER 219 74 2272 | 5. SEX | 8. AGE (In y | vrs. last birthday) YRS. | IF UNDER | 1 YEAR | | | 7. DATE OF BIRTH (Month, Day, Year) Jan. 15, 19 | | Count | HPLACE (State or Fore | |
| - B | 90, FACILITY NAME (If not institution, gi Anne Arundel Ge | neral Hos | pital | | 96. CITY, TOWN OR LOCATION OF DEATH Annapolis | | | | | 9c. COUNTY OF CEATH Anne ARundel Count | | | |
| DIRECT | PESIDENCE OF DECEDENT 10a. STATE 10b. COU MD Anne | | | 10c. CITY, TOWN OR LOCATION Shady Side | | | | | | | | | |
| ERAL | 10e. STREET AND NUMBER | ive | | | nauy | | II. ZIP CODE | 20764 | | 10g. CITT | ZEN OF | 1 ☐ YES 2 ☒ NO | |
| BY FUN | 11. MARITAL STATUS 1 🔀 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS OECEDER FORCES? IF YES, GIVE | I VES | 2 MNO | | If yes, sp | CENOENT OF HIS pecify Cuben, Mer | PANIC ORIG | RIGIN? (Specify Yea or No— 14. I erto Rican, etc.) | | | E - American Indien ck, White, etc. offy: White | |
| PLETED | 15. DECEDENT'S E (Specify only highest gr Elementery/Secondery (0-12) 1 2 | DUCATION ade completed) College (1-4 or 5 | +) | Sa. DECEDENT'S (Give kind of v life. Do NOT us | vork done e retired.) | | | 1 | 8b. KIND OF BU | JSINESS/IND | USTRY | WILLE | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | OMGODO T | | Carpent | er | | | | , Middle, Maide | | ion | | |
| TO BE | 19e. INFORMANT'S NAME (Type/Print) | orseman I | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, (| | | | | | mber, City or To | | | | |
| | Peggy June 20a. METHOD OF DISPOSITION 1 D Buriel 2 & Cremetion 3 D R | | 20b. Pt | ther place) | SITION (Na | me of ce | Side Rd | or | 20c. L | e, MD | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE | LICENSEE 9 | | ме | | | nd Address of | | y Al | exandı | ria, | VA_ | |
| | 23. PART I. Entar the diseases, I shock, or heart failu | or complications the | at caused th | na death. Do n | R Dt antar | tha mo | ch Fune oda of dying, s | ral H | ome, O | Wings piretory am | , MI | Approximat | |
| | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a. Multip | le inj | n lina. | ot antar | tha mo | Ch Fune | ral H | ome, O | Wings Diretory am | , MI | | |
| ERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. Multip OUE TO DUE TO C. | le inj | Uries ONSEQUENCE OF | ot antar | tha mo | ch Fune | ral H | OME, O | Wings piretory arm | , MI | Approximat Interval Bet | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Multip oue To b. Due To c. Due To | le inj | Uries DISSOURCE OF DISSOURCE OF | not antar | tha mc | oda of dying, a | uch as ca | rdiac or reag | N AUTOPSY | est, | Approximat Interval Bet | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of th | a. Multip OUE TO b. DUE TO c. DUE TO d. HOSPITAL: | le inj O (OR AS A CO O (OR AS A CO O (OR AS A CO | Uries DISSEQUENCE OF DISSEQUENCE OF DISSEQUENCE OF | ot antar | the mo | g cause given | In Part I. | 24a. WAS AI PERFO | N AUTOPSY | est, | Approximat Interval Bet Onset and 1 Onset | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the condition of the condition o | b. DUE TO d. HOSPITAL: 1 Inpatient 20 28a. DATE OI 1 Month 6 | D (OR AS A CO | Uries DISSOURNCE OF DISSOURNCE | OTHES | 26. Pi | g cause given LACE OF OEATH | In Part I. | 24a. WAS AI PERFO XX YES | N AUTOPSY RIMED? 2 \(\text{NO} \) INJURY OCC | 24t | Approximat Interval Bet Onset and 1 Onset | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of | BDNa CDNtributing to HOSPITAL: 1 Inpatient 20 28e. DATE On 11 29e. PLACE Obuilding to | O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO O (OR AS A CO | Uries DISSOURNCE OF DISSOURNCE | OTHES | 26. Pi | g cause given LACE OF CEATH, no 5 Resident JURY AT JURY 2 | In Part I. Check only 28d. D. 28d. D. 28d. D. | 24a. WAS AL PERFO XM YES one) her (Specify) ESCRIBE HOW LCSTON (Street | NAUTOPSY RIMED? 2 NO INJURY OCCUR IN STY | 24k | Approximat Interval Bet Onset and 1 Onset | |
| AL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of | BDNa CDNtributing to HOSPITAL: 1 Inpatient 20 28e. DATE On 11 29e. PLACE Obuilding to | De inj O (OR AS A CO O (OR AS | DIVICES DISEOUENCE OF DISEOUENCE OF DISEOUENCE OF DISEOUENCE OF DISEOUENCE OF DISEOUENCE OF At home, farm, a | OTHER | 26. Pi | g cause given LACE OF OEATH, no 5 Resident JURY AT YES 2 RO | In Part I. Check only as a or 28d. D Peo | 24a. WAS AI PERFO XII YES one) ber (Specify) ESCRIBE HOW CSTY CST | NAUTOPSY PRIMED? 2 NO INJURY OCCAN STY and Number & HC lel Ce | 24k | Approximatintarval Bet Onset and 1 Onset a | |
| D BY PHYSICIAN: MEDICAL CERTIFICATION | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of | B. Multip OUE TO b. DUE TO c. DUE TO d. DUE TO | DER/Outpatie | DISEOUENCE OF DI | OTHER | 26. Pi | g cause given LACE OF OEATH, no 5 Resident JURY AT YES 2 RO | in Part I. Check only 28d. D Pec 28f. LC All the companion of the com | 24a. WAS AI PERFO XII YES one) ber (Specify) ESCRIBE HOW CSTY CST | NAUTOPSY RIMED? 2 NO INJURY Occan Strain St | 24th 24th 24th 24th 24th 24th 24th 24th | Approximatintarval Bet Onset and 1 Onset a | |



COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BE 2

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|-----------|---|---|-------------------|--|--|-----------|-----------------|--|-----------|-------------|--|--|
| | FOR STATE OF MAR REGISTRAR | | | ICATE | | | | MENTAL HYGIEN | E | | 0400, | |
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) Charles, Foward, Hornbarger, Jr. 2. Date of Death Month 12 - 4-90 YEAR 2 | | | | | | | | | | | |
| 1 | 218342449 XH20F 1 | GE (In yrs. last | birthday) YRS. | IF UNDER 1 | YEAR DAYS | IF UNDER | 24 HRS, MIN, | 7. DATE OF BIRTH (Mgnth, Day, Year) | 37 | Country | Yland | |
| OB | 9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital | | | 96 CITY, T | | | ON OF DE | ATH | 9c. COL | | y of DEATH Harford | |
| DIRECTOR | | | | | LOCATIO | ON | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 XNO | |
| FUNERAL | 10a. STREET AND NUMBER 2203 Willoughby Beach Road | | | | - | ZIP CODE | 040 | | | | HAT COUNTRY? | |
| B | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER FORCES? 1 YES, GIVE WAR O | ES 2 SAN | | If y | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 VES 2 NO Specify: Specify: White, etc. | | | | | White, etc. | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver 16b. KINO OF BUSINESS/INOUSTRY Air—Products—Ch | | | | | | | | | hemical | | |
| BE CO | 17. Father's NAME (First, Middle, Lest) Charles Edward Hornbarger, Sr. 18. MOTHER'S NAME (First, Middle, Meiden Surname) Mary Ann Hornbarger | | | | | | | | | | | |
| 10 8 | 19a. INFORMANT'S NAME (Type/Print) Charles E. Hornbarger, III | | | ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) t.D, Windstream Way, Edgewood, Md. 21040 | | | | | | 21040 | | |
| | 20a. METHOO OF DISPOSITION 1 X Burlai 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) | otner plac | 20) | SITION (Name of cemetery, crematory or U. M. Cemetery Abingdor | | | | | | | - | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE HOLLIANS K Mc Com. | HOWard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. | | | | | | me, P.A. | | | | |
| | 23. PART I. Enter the diseases, or complications that caushock, or heart feiture. List only one cause of IMMEDIATE CAUSE (Final disease or condition | used tha dec on sech line. | th. Do r | not enter th | na mod | le of dyl | ng, such | ae cardiec or reapi | ratory er | rrest, | Approximate interval Between Onset end Death | |
| _ | reaulting in death) | AS A CONSEC | Test of | DO-KI | مرد | y o | | refo | | | | |
| NOIL | Sequentisliy list conditions, if any, leading to immediate | AS A CONSEQ | UENCE OF | F): | - | | _ | _ | _ | | | |

cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated evants resulting in death) LAST

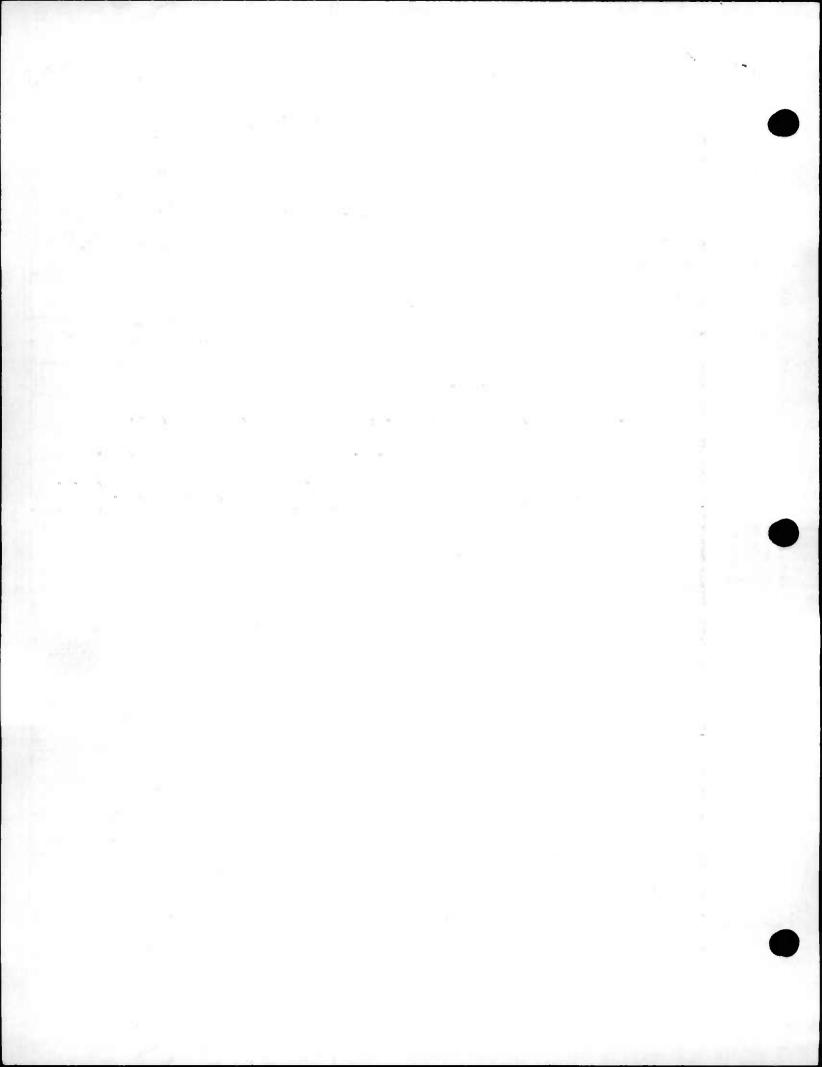
PART II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 1 YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one)

HOSPITAL:
1 | Inputiant 2 | ER/Outputiant 3 | DOA OTHER: 1 YES 2 NO ng Home 5 - Residence 8 - Other (Specify) 27. MANNER OF OEATH 28c. INJURY AT WORK?
1 YES 2 NO 28a. OATE OF INJURY (Month, Day, Year) 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED 1 Natural 2 Accident 28e. PLACE OF INJURY — At home, farm, atreet, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide a Could not be determined 4 Homicide

29a, CERTIFIER 1 CERTIFY the best of my knowledge, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CE

TEO CAUSE OF PEATH (ITEM 27) (Type DEC 05 9

32. REGISTBAR'S SIGNATURE



|) | | nit. Pages 1, 2, 3 should |
|--------------------------------|---|---|
| BALTIMORE, MARYLAND 21203-3146 | after death. Page 6 may be retained by the hospital or attending physician. | ly the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should |
| ALTI | death. | e funeral |
| 8 | after | y th |

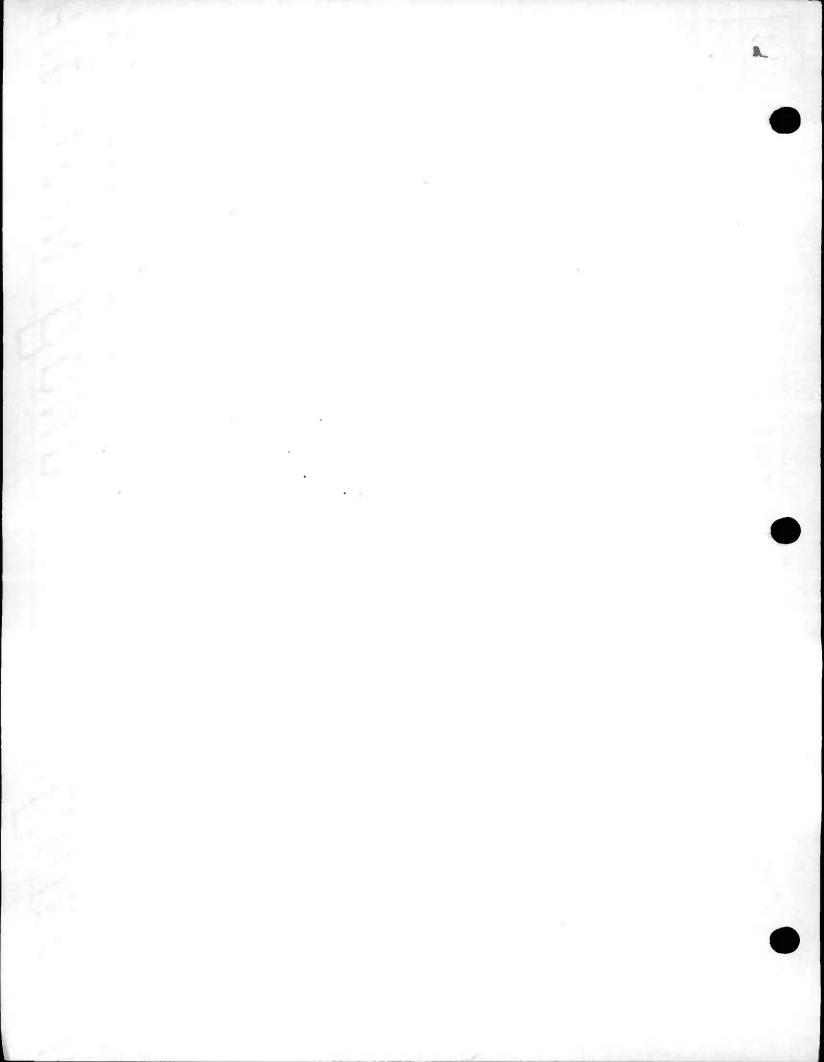
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 3 IGNOS 38 OT | ON DE COMPLETED DY DUVOICIAM: MEDICAL CEDTIFICATION |
|--|--|
| al. examiner must be notified at once. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| ne funeral director, page 5 should be detached for | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for |
| r death. Page 6 may be retained by the hospital or | THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2x mours after death. Page 6 may be retained by the hospital or |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

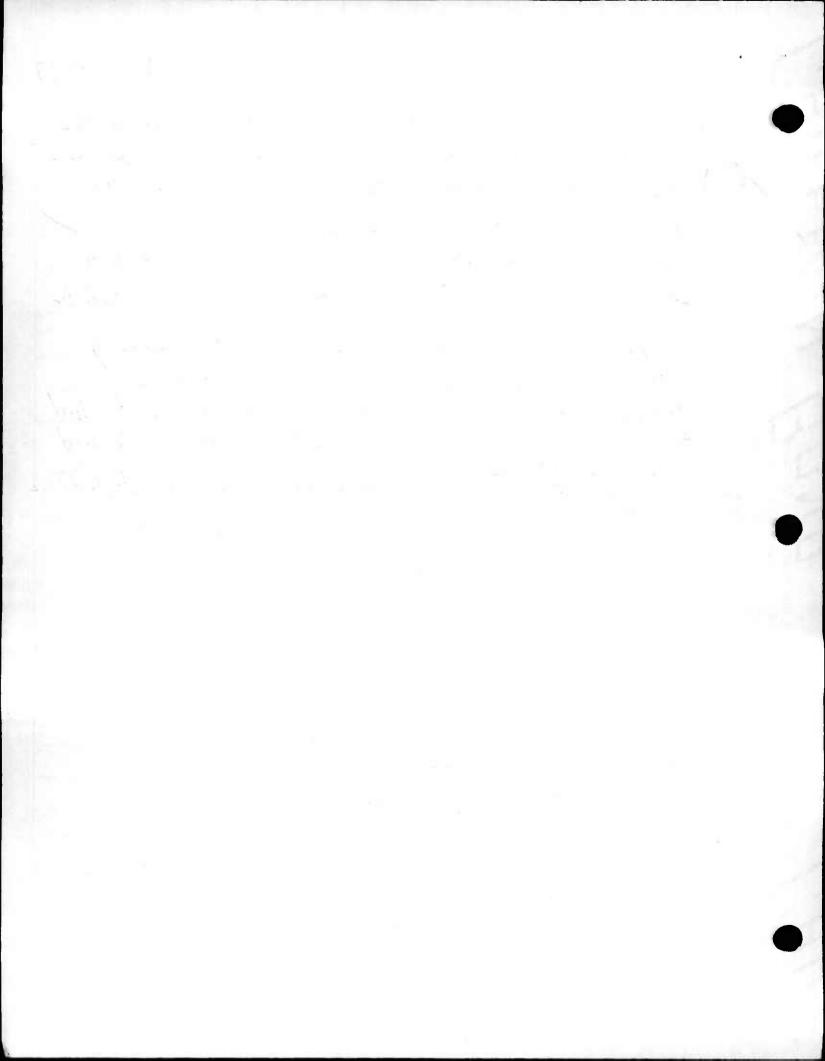
31. DATE FILED (Month, Pey, Year)
DEC 05 90

| | | | | | | (| 90 34386 | |
|--|--|--|------------------|-------------------------|--|------------------|---|--|
| FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | MENT OF | HEALTH AND | MENTAL HYGIEN REG. NO | E | 0 04000 | |
| 1. DECEDENT'S NAME (First, Middle, Lest) | HAYES | | | | 2. DATE OF DEATH MONTH D. | AY | YEAR 06 0EATH | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX / 6. AGE (| The state of the s | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | S. BIRTHPLACE (State or Foreign Country) | |
| 214-56-2543 | 1 □ M 2 🂢 F | 103 YRS. | DAYS | HOURS MIN. | 12-25-1886 VA | | | |
| 9a. FACILITY NAME (If not institution, give | on conserve | TIL. AVE | | OR LOCATION OF D | EATH | | TY OF DEATH | |
| Liberty Medical | <u>Center 2600 L</u> | iberty | Balti | imore | | city | / | |
| 10a. STATE 10b. COUNT | ry | 10e. CITY, T | OWN OR LOC | ATION | | | 10d. INSIDE CITY | |
| MD Balti | more city | Bal | timore | city | | | 1 X YES 2 NO | |
| 10e. STREET AND NUMBER | | | 1 | Of. ZIP CODE | | 10g. CITIZE | EN OF WHAT COUNTRY? | |
| 2627 Mosher St. | To the control of the | Construction of | 200 | 21216 | | | JSA | |
| 1. MARITAL STATUS Never Married 2 Married | 12. WAS DECEDENT EVER II FORCES? 1 YES | 2 XNO | If yes, s | specify Cuben, Mexic | NIC ORIGIN? (Specify Ye en, Puerto Rican, etc.) | or No- 1 | 4. RACE — American Indian, Black, White, atc. | |
| Widowed 4 Divorced | IF YES, GIVE WAR OR D | ATES | 1 1 4 | S 2 X NO Speci | Ty: | | specify: Black | |
| 15. DECEDENT'S ED | UCATION le completed) | 16a. DECEDENT'S US | k done durina r | FION most of working | 16b. KIND OF BU | SINESS/INDU | STRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ille. Do NOT use n | etired.) | in a secondary | | | | |
| 77. FATHER'S NAME (First, Middle, Last) | | Housew | ife | I a marijana u | AME (First, Middle, Maiden | | | |
| Georges Willia | me | | | Marth | | Sumame) | | |
| 19a. INFORMANT'S NAME (Type/Print) | IIIS | 19b. MAILING AL | ODRESS (Stree | | Route Number, City or Toy | vn. State. Zio C | Code) | |
| Evelyn Whitt | | | | | imore, MD | , | 4,100 | |
| 20s. METHOO OF DISPOSITION | 200 | other place) | | | | CATION — CI | ity or Town, State | |
| Donation 5 Dother (Specify) | 100 | West | ern St | tar Cem. | Ba | ltimor | re, Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE / | | Arno | | ard Funera Havre de | | | |
| 23. PART I. Enter the diseases, or | complications that cause | d the desth. Do not | | | | | | |
| shock, or haart failure IMMEDIATE CAUSE (Final | . List only one cause on a | | | | 1 | | Interval Between Onset and Death | |
| disease or condition | . SEPS | 15 2° : | SKIN | ULCERATI | on | | | |
| resulting in destily | • | A CONSEQUENCE OF): | | | | | | |
| Sequentially list conditions, | a INFEC | TED DEC | UBITU | 15 - SACA | IAL ULCE | ER | | |
| if any, leeding to immediate cause. Enter UNDERLYING | | | | | | | | |
| CAUSE (Disease or Injury that initiated events | DUE TO (OR AS | A CONSEQUENCE OF): | ENI | DIABELE | S MELLIT | 45 | <u> </u> | |
| resulting in death) LAST | CHRON | ILC RENA | +L FA | FILLARE | | | | |
| DART II. Other significant condition | | | | | D 41 44 44 | | | |
| PART II. Other algorificant condition | el Vascular | | | ing cause given i | | RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE | |
| Old Collos | 00 14100-000 | Access | | | 1 TES | 2 🗌 NO | OF DEATH? | |
| | 0-1 | | | | | | 1 TES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. | PLACE OF DEATH (C | theck only one) | | | |
| EXAMINER? | HOSPITAL: | | OTHER: | ome 5 🗆 Rasidence | 6 Other (Specify) | | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME (| OF 26c. | NJURY AT WORK? | 26d. DESCRIBE HOW | INJURY OCC | URED | |
| 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | | |
| 3 Suicide 6 Could not be | 26a. PLACE OF INJUR' building, etc. (Spe | Y — A1 home, farm, atn polity) | eet, factory, of | fice | 26f. LOCATION (Street City or Town, State | | or Rural Route Number, | |
| | | | | | <u> </u> | | | |
| (Original Origina Origina Origina Origina Origina Origina Origina Origina O | SICIAN: To the best of my known NER: On the basis of examination | | | | | | ed. o cause(e) end menner ex stated. | |
| 296. SIGNATURE AND TITLE OF CERTIF | temo | | | 29c. LICENSE N | | 29d. DATE | SIGNEO (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON V | | FATH (ITEM 27) (Tone S | rint) | 100 | 5788 | 1 | 1/25/90 | |
| | BERITY MEDICA | | | MORE. N | D Z1215 | | | |
| A Landing | 1 11 | | 2011-1 | | | | | |



| rs after death. Page 6 may be retained by the hospital or attending physician. | n by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should removal. | edical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIRECTOR |
|---|--|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| FOR STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTM | | | MENTAL | REG. NO. | | 0 34307 | |
|--|--|---|---------------------------|--|-------------------|------------------------------------|----------------|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SonuA | HAI | rock | | | 2. DATE (| OF DEATH DAY | 199× | 3. TIME OF DEATH | |
| 00 00/7/1/00 | SEX 8. AGE (II | | UNDER 1 YEAR HTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | (Month) | DE BIRTH Day, Year) 26,19 | 8.8 | HRTHPLACE (State or Foreign Jountry) | |
| 9a. FACILITY NAME (If not institution, give street | | | | | | | | | |
| RESIDENCE OF DECEDENT | | | | | | | | | |
| md. CAI | Mc. CArroll Manchester 11 | | | | | | | | |
| 100. STREET AND NUMBER 2737 BACKMAN Rd. 101. ZIP COOE 102. CITIZEN OF WHAT 2/102 103. CITIZEN OF WHAT | | | | | | | | | |
| 1 Never Married 2 Married | P. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 NO | If yes, sp | ENDENT OF HISPAN polity Cuben, Mexica NO Specify | n, Puerto R | | or No— 14. | RACE — American Indian, Black, White, etc. | |
| 3 Development 4 Divorced 15. DECEDENT'S EDUCAT | ION | 16a. OECEDENT'S US | | | 16b. | KIND OF BUSI | NESS/INDUST | WHITE | |
| (Specify only highest grade con Elementary/Secondary (0-12) | npleted) College (1-4 or 5+) | (Give kind of work life. Do NOT use re | etired.) | st of working | | , / | | King | |
| 17. FATHER'S NAME (First, Middle, Last) JOGY Wes | Ley SAU | 1K | | 18. MOTHER'S NA | ME (First, N | fiddle, Malden S | iumame) | | |
| 190. INFORMANT'S NAME (Type/Print) JA CQUE!LLE B | HANCOCK | 196, MAILING AD | DRESS (Street a | nd Number or Rural I | Poute Numb | er, City or Town | State, Zip Coo | ester Md | |
| 20e,METHOD OF DISPOSITION 20e,METHOD OF DISPOSITION 3 Remova 4 Donation 5 Other (Specify) | 20b. | PLACE OF DISPOSITI | 1 D' | netery, crematory or | | 20c Loc | ATION — City | or Town. State | |
| 21. SIGNATURE OF FUNERAL SERVICE LICEN | 0 H | Druje | | DADDRESS OF FA | CILITY | raem | 1 6 | hipe | |
| 23. PART i. Enter the diseases, or con | npilcations that caused | the death. Do not | 3296 | de of dving, suc | h ss cerd | Dr. VI | MAUCH | Y Approximate | |
| ahock or heart failure. Lis IMMEDIATE CAUSE (Final | t only one cause on a | ich lina. | | | | | | Interval Between Onset and Death | |
| disease or condition resulting in death) | | CONSEQUENCE OF): | IVER | WITH | M | ETASTE | 2121 | | |
| Sequentially list conditions, | | CITES CONSEQUENCE OF): | | | | | | Ś | |
| If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | |
| that initiated eventa resulting in death) LAST | OUE TO (OR AS A | CONSEQUENCE OF): | | | | | | | |
| PART II. Other algnificant conditions of | | ut not resulting in | tha underlyin | g ceuse given in | Part i. | 24a. WAS AN / | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| | DOD IKE | 5,44,6 | | | _ | 1 YES 2 | □ NO | COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL | | | 28. PI | ACE OF DEATH (Ch | eck only on | a) | | | |
| EXAMINER? 1 YES 2 NO 1 | IOSPITAL: Inpetient 2 ER/Outp | | THER: | 6 5 Phasidence | | | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a, DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WC | URY AT PRK? YES 2 NO | 28d. DES | CRIBE HOW IN | JURY OCCUR | ED | |
| 3 Suicide 8 Could not be 4 Homicide determined | 26s. PLACE OF INJURY building, etc. (Spec | — At home, farm, stre | et, factory, offic | • | 28t, LOC. City | ATION (Street a or Town, State) | nd Number or F | Rural Route Number, | |
| | N: To the best of my knowl | | | | | | | use(a) and manner as stated. | |
| 20b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUI | | | 29d. DATE SI | GNED (Month, Day, Year) | |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Pr | int) | | | 0.11.5 | | | |
| 31. DATE FILED (Month, Day, Year) | ESTER ROP 32. REGISTRAR'S SIGN Julia Dav | ATURE YOUR | VLI(ES | IEK, | MI). | 2110 | _ | | |
| DEC 3 - '90 | Julia Dav | 14001-Northern | | | | | | OHMH-16 Rev 1/89 | |



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| SICIAN: The law req | certificate has been | d, or item 23 shov |
| PHYSICIAN: The law req | r this certificate has been | arked, or item 23 show |
| IDING PHYSICIAN: The law req | After this certificate has been | is marked, or item 23 show |
| ATTENDING PHYSICIAN: The law req | CTOR: After this certificate has been | 28 is marked, or item 23 show |
| OR ATTENDING PHYSICIAN: The law req | DIRECTOR: After this certificate has been | item 28 is marked, or item 23 show |
| ITAL OR ATTENDING PHYSICIAN; The law req | RAL DIRECTOR: After this certificate has been | If Item 28 is marked, or Item 23 show |
| JOSPITAL OR ATTENDING PHYSICIAN: The law req | UNERAL DIRECTOR: After this certificate has been a | ANT: If Item 28 is marked, or Item 23 show |
| HE HOSPITAL OR ATTENDING PHYSICIAN; The law req | HE FUNERAL DIRECTOR: After this certificate has been a matrix 72 hours after death with the State Death of L | ORTANT: If Item 28 is marked, or Item 23 show |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Zerofurs after death. Page 6 may be retained by the ho | TO THE FUNERAL DIRECTOR: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detacted as the funeral director, page 5 should be detacted as the funeral director, page 5 should be detacted as the funeral director, page 5 should be detacted as the funeral director, page 5 should be detacted as the funeral director, page 5 should be detacted as the funeral director and funeral directors. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |

| | FOR STATE REGISTRAR | STATE OF MA | | | TMENT ICATE | | | | MENTAL HYGIEN REG. NO | | | |
|------------------|--|--|---------------------------------|---|--|--|-------------------|-------------------|---|--|---------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Lest) | ACOLD | HA | M16 | -10 | 2 | - | | 2. DATE OF DEATH | AY C | VEAD | TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER 216-22-1686 | 5. SEX 1 M 2 D F | AGE (In yrs. lest I | oirthday) YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER HOURS | 24 HRS. MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 22 | Country) | CE (State or Foreign |
| OR | on. FACILITY NAME (If not institution, give s Carroll County | | Hospi | 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH | | | | | | | | |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY Maryland Ca | rroll | | 10c. CITY, TOWN OR LOCATION Westminster | | | | | | 10d. INSIDE CITY LIMITS? 11 YES 2 □ NO | | |
| ERAL (| 100. STREET AND NUMBER 302 Buena Vist | a Drive | | 10f. ZIP CODE 21157 | | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorcad | RITAL STATUS 12. WAS DECEDENT EVER IN U.S. J FORCES? 1 ☐ YES 2 ☑ IF YES GIVE WAR OR DATES | | | | MED 13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No 14. RACE — America (If yes, specify Cuban, Maxican, Puarto Rican, atc.) | | | | | | American Indian, hita, etc. White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondery (0-12) | | (Glv | kind of Oo NOT u | usual oc work done of se retired.) | during mo | st of workin | | Cong | oleu | | cp. |
| BE COA | 17. FATHER'S NAME (First, Middle, Lest) Calvin Harris | on Hamil | ton | | | | | | ME (First, Middle, Meider Jamison | | | |
| TOB | 19a. INFORMANT'S NAME (Type/Print) Catherine Henr | У | 19b. | 130 | ADDRESS 49 (|) per | nd Number 1 He | or Aural A art | h Way, G | vn, State, Zip erma | ntown | 20874 |
| | 20a METHOD OF DISPOSITION 1 Paurial 2 Cremetion 3 Ram 4 Donation 5 Other (Specify) | | 20b. PLACE O | ree | en Me | me of cen | rial | atory or Ga: | | inks | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY FLETCHET FUNETAL | | | | | | | neral Ho In Md tree | me 157 | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or reapiratory arrest, interval Between shock, or heart failure. List only one cause on each line. | | | | | | | | Approximata interval Between Onset and Death | | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | 25 DAYS | | | |
| MEDICAL | SEPTICEMIA ARTERIOSCLEROTIC HEART DISEASE PERFORMED? 1 YES 2 PHO OF DEATH 1 YES 2 PHO 1 YE | | | | | | | | ERE AUTOPSY FINDINGS ANABLE PRIOR TO DMPLETION OF CAUSE DEATH? YES 2 NO | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | R-47T1 | | OTHE | t : | | | eck only one) | | | |
| ву рну | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF IN (Month, Day, | JURY | 28b. TII | | 28c. INJ WC | | | 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OCC | CURED | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF I building, etc | INJURY — At hor c. (Specify) | ie, farm, | atreet, fact | iory, offic | • | | 28f. LOCATION (Stree City or Town, State | | or Rural Roul | e Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYS | | | | | | | | | | | nd manner as stated. |
| TO BE | 296 SIGNATURE AND TITLE OF CERTIFIE | whom | | YSIC | IAN | | 29c. LICI | ENSE NUN | SS. | 29d. DATE | 30 /30 | onth, Day, Year) |
| | | MD 524 | +-B BA | الما | o, Print) | BL | VD, | WE: | STOW STE | R, M | 02 | 1157 |
| | off 3 - 190 | A The Davids | s significan | | | | | | | | | |
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BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 media after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages to fill within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| | 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | IENT OF H | EALTH AND DEATH | MENTAL HYGIEI | | 0,00. | |
|-----------------------|---|---|---|-------------------------------------|---|--|------------------------------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | 1 | 2. DATE OF DEATH | DAY | YEAR 3. TIME OF DEATH | |
| | | . Hargadon | | 125 | £ | 111 2 | 7- | 90 10:15 M | |
| | 4. SOCIAL SECURITY NUMBER 213-36-5385 | 1 M 2 □ F | | UNDER LA EAR | IF UNGER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 9/5/37 | 8 | BIRTHPLACE (State or Foreign Country) Maryland | |
| TOR | 90. FACILITY NAME (If not Institution, give | unt Jen. | Hosp (| | n bia | MA | | YOF DEATH | |
| DIRECTOR | Md. How | vard | | cott C | | | 10d. INSI LIMI 1 _ YE: | | |
| AL | 10e. STREET AND NUMBER | | | 101. ZIP CODE | | | 10g. CITIZE | N OF WHAT COUNTRY? | |
| ij. | 3788 Plum Spring | | | 21043 | | | | USA | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | ever Merried 2 Merried FORCES? 1 YES 2 | | | ENDENT OF HISPA ecity Cuben, Mexico 2 NO Specia | NIC ORIGIN? (Specify Youn, Puerto Ricen, etc.) | e or No— | 4. RACE — American Indian, Black, White, etc. Specify: White | |
| | 15. DECEDENT'S EDI (Specify only highest grad | JCATION e completed) | 18e. DECEDENT'S USU (Give kind of work | AL OCCUPATIO | ON . | 16b. KIND OF BE | SINESS/INDUS | | |
| | Elemantary/Secondery (0-12) | College (1-4 or 5+) | life. Do NOT use ret | tired.) | st or working | | | | |
| COMPLETED | | 4 | Admin | istrat | or | Dept. | of De: | fense | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Maide | Sumame) | | |
| BE | Eugene Hargadon | · | | | | ea Becker | | | |
| 2 | 190. INFORMANT'S NAME (Type/Print) Bernardine A. Ha | | | | | Route Number, City or To | | | |
| | 20a_METHOD OF DISPOSITION | | | | | , Ellicot | | | |
| 1 | 1 Donetion 5 Other (Specify) | noval from Stata | other place) Loudon Par | | | | | | |
| | 21. SIGNATURE ON NUMERIAL SERVICE U | L. Koub | neno | Gary | L. Kauf Main St | man Funera ., Elkrida | l Home | es 21227 | |
| CERTIFICATION | immediate cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | e. A Co te R DUE TO (OR AS A DUE TO (OR AS A DUE TO (OR AS A | CONSEQUENCE OF): | y Far | Approximate interval Between Onset and Death | | | | |
| PHYSICIAN: MEDICAL CE | Acole Ring | ea undariying | | | | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | |
| 호 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | 0.7 | 26. PL/ | ACE OF DEATH (Ch | eck only one) | | | |
| ΥS | 1 TYES 2 NO | 1 Inpatient 2 ER/Outpa | itlent 3 DOA 4 D | Nursing Home | 5 🗆 Reeldence | 8 Other (Specify) | | | |
| BY PH | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WOF | IRY AT RK? ES 2 NO | 28d, DEŞCRIBE HOW | NJURY OCCUP | RED | |
| | 2 Accident Investigation 3 Suicide 8 Could not be determined City or Town, State) 4 Homicide 1 Accident 1 Accident Street and Number or Rural Route Number, City or Town, State) 28e. PLACE OF INJURY — At home, term, street, tectory, office City or Town, State) | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSIC MEDICAL EXAMINE | CIAN: To the best of my knowle | edge, death occurred at | the time, date or my opinion, de | end place, end due ath occured at the | to the ceuse(e) end me | nner ee stated. | euse(e) end manner ee stated. | |
| TO BE (| 29b. SIGNATURE AND TITLE OF CERTIFIE | n ut! | KNO | | 29c. LICENSE NUM | | | IGNED (Month, Day, Year) | |
| | 30. NAME AND ADDRESS OF PERSON WHO | | TH (ITEM 27) (Type, Print | | M riv | D 2104 | 4 | | |
| | 31. DATE FILED (Month, Day, Year) NOV 3 0 '90 | 32. REGISTRAM'S SIGNA | | | | | | | |

FOR STATE REGISTRAR

NADINE

4. SOCIAL SECURITY NUMBER

1. DECEDENT'S NAME (First, Middle, Leat)

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6. AGE (In you last birthday) I D M XX 65 218-16-4403 07-17-1925 Se. FACILITY NAME (If not institution, give appeal and number 9b. CITY, TOWN OR LOCATION OF DEATH DIRECTOR Memorial Hospital Cumberland 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD **Allegany** Cumberland, FUNERAL 10s. STREET AND NUMBE 10f. ZIP CODE 19 West Industrial Blvd. burtat-transit 21502 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 VES 2 XX00 IF YES, GIVE WAR OR DATES WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or if yea, specify Cuban, Mexican, Puerto Rican, etc.)
 U YES XX NO Specify. 1 Never Married XX Married 84 9 3 Widowed # Divorced detached for use as COMPLETED 15. DECEDENT'S EDUCATION His. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working the Do WOT use retired.) (Specify only highest grade co 16b, KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) Callege (1-4 or 5 +) former employee Doespun once. 17, FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) Ona S. Hersman 80 Ħ BE Marie Davis notified page 5 should 19s. INFORMANT'S NAME /Type/Print 19b. MAILING ADDRESS (Street and Number or Flurel Route Number, City or Tiwn, State, Zip Code 2 19 West Industrial Blvd. Cumberland, MD 21502 Mr. William Hunt 8 METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cumutary, crematory or must Y ☐ Burlet 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) 3. D. R funeral director. Terra Alta Cemetery 21. SIGNATURE OF FUNERAL SERVICE LICENSE examiner 22. NAME AND ADDRESS OF FACILITY
Scarpelli Funeral Home Cumberland, MD 21502 filled in by the f on, or removal. medical 23. PART Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List IMMEDIATE CAUSE (Final repletely filter cremation. 2 disease or condition resulting in death) traumatic event. and com burtal, i CERTIFICATION Sequentially list conditions, prior to If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury or other the attending phy Mental Hygiene o that initiated events resulting in death) LAST injury. PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. MEDICAL 24a. WAS AN AUTOPSY PERFORMED? 25 any signed b 1 | YES 2-110 t. of Heath shows a PHYSICIAN: Dept. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? certificate to the State I, or item them 26. PLACE OF DEATH (Check only one HOSPITAL: OTHER: 1 YES 2 WO ne 5 🗆 Beside 27. MANNER OF DEATH 26s. DATE OF INJUST (Moxe), Day, Year) this c marked. 28b. TIME OF 284. DESCRIBE HOW INJURY OCCURED 28c. INJURY AT WORK? T Autural 5 Pending AE HOSPITAL OR ATTA.
"WERAL DIRECTOR: Ann.
"Phouse after dean."
"Phouse after dean." BY 1 YES 2 NO 2 Accident 3 🔲 Suicide 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) COMPLETED 8 Could not be 4 🗌 Homicide 29e. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(e) and manner as stated TO THE HOSPITAL
TO THE FUNERAL
Be filed within 72 IN 2 MEDICAL EXAMINER: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) end manner ee stated. 296. SIGNATURE AND TITLE OF CEREFIER BE 29c. LICENSE NUMBER 29d. DATE SIGNE (Mooth Day, Year) an D23371 12 2 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. Zaman Memorial Hospital Medical Building Cumberland, MD. 21502

32. REGISTRAR'S SIGNATURE

CERTIFICATE OF DEATH

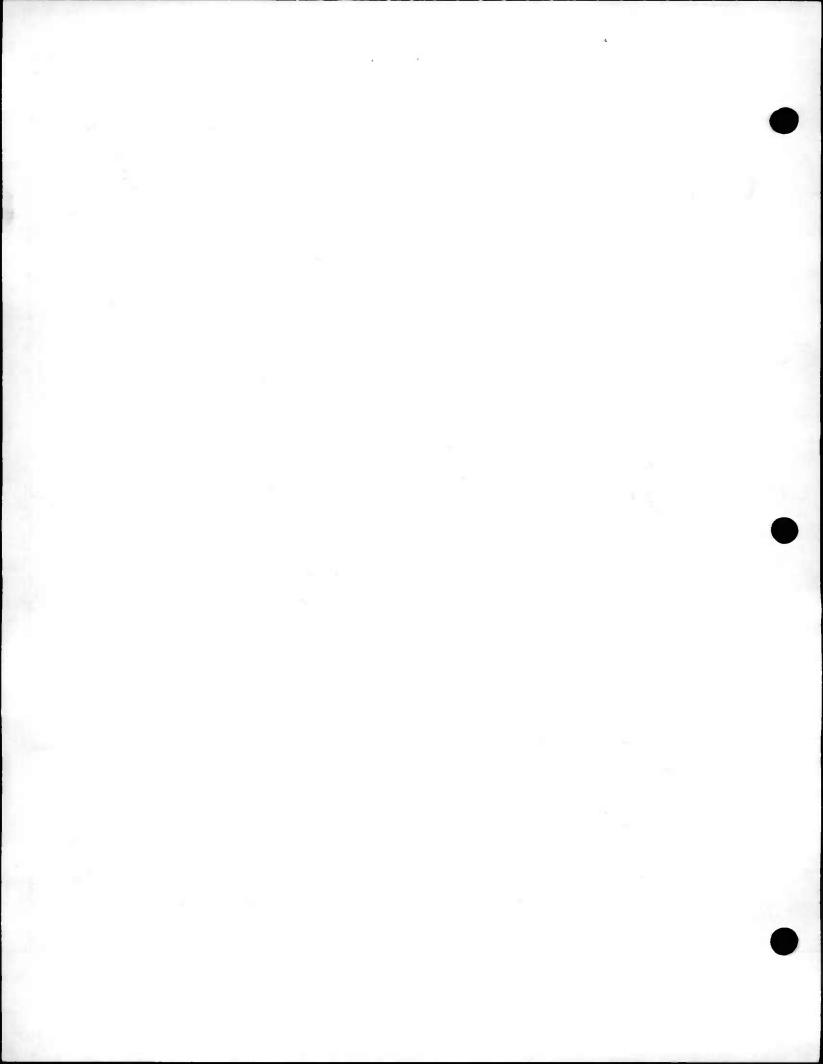
HUNT

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REG NO 2. DATE OF DEATH 3. TIME OF DEATH December 4, 1990" 8:07 A 7. DATE OF BIRTH B. BIRTHPLACE (State or Formio WV Sc. COUNTY OF DEATH Allegany 10d. INSIDE CITY LIMITS? XX YES 2 NO 10g. CITIZEN OF WHAT COUNTRY! white 20c. LOCATION — City or Town, State Terra Alta, WV Approximate Interval Betwe Onset and Death 24h. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 28f. LOCATION (Street and Number or Rural Routs Number Oby or Reen, State)

31. DATE FILED (Month, Day, Year) 06 1990

EC

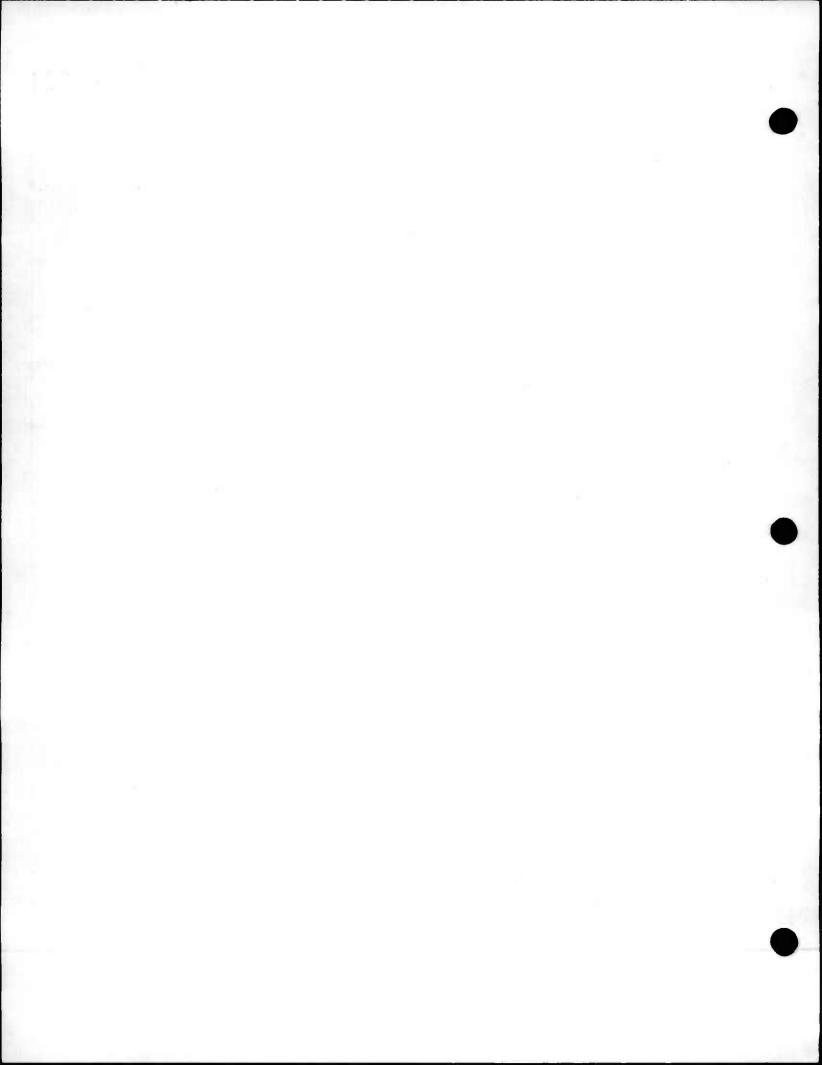
90.



| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death cetificate be executed within 2 lours after death. Page 6 may be retained by the host | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached author and a | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| ned by | onld be | led at |
| e retair | 5 Sho | notif |
| may b | or, pag | ust be |
| Sage 6 | directi | er mu |
| leath. | funeral | xamin |
| after (| by the | ical e |
| SUDOIL . | lled in | med e |
| thin 2- | etely fi | II. IB |
| uted wi | compl | c eve |
| Dece exec | an and | umat |
| ficate b | physici ne pho | er tra |
| th certi | ending Hvnie | 0r of |
| he deat | the att | nluy. |
| that t | th and | any i |
| equires | en sign | hows |
| e law r | has be | 1 23 8 |
| AN: Th | lificate State | r Item |
| HYSICI | his cer | ced, o |
| DING P | After t | mari |
| ATTEN | CTOR: | 28 18 |
| AL OR | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fire a signal within 20 hours often death with the State Deat of Health and Mental Horiene prior to build cremation, or removal. | I Item |
| 10SPIT | UNERA | ANT |
| THE | THE P | PORT |
| B | P 2 | 3 = |

| 1 - STATE REGISTRAR | | | CI | EHITIC | AIE | F DEA | TH | REG. NO. | | | |
|---|--|---|--------------------------------|--|--------------|-----------------------|----------------------|--|-----------------------------|------------------------------------|-----------------------------|
| 1. DECEDENT'S NAM | NE (First, Middle, Last) | | | | | | | 2. DATE OF DEATH MONTH DA | W) | YEAR 3. | TIME OF DEATN |
| | George | ۶ | Adolph | Н | ofman | n, Sr. | | 11-24-9 | 90 | | 2:05PM M |
| 4. SOCIAL SECURITY | | 5. SEX | 6. AGE (In yrs. las | | UNDER 1 YEA | | | 7. DATE OF BIRTH (Month, Day, Year) | 0. | . BIRTHPLA Country) | CE (State or Foreign |
| 212-26- | 6700 | 1) ()⁄M 2 □ F | 62 | YRS. | NTHS DAY | HOURS | MIN. | 6-27-28 | | Ha | ryland |
| | (If not institution, give s oklyn Bri | | | 98 | | m on Locati Laurel | | TN | 9c. COUNT Prin | | eorges Co. |
| RESIDENCE OF | | | | | | | | | | | |
| | 10b. COUNT | | | 10c. CITY, T | | CATION | | | 10d. INSIDE CITY LIMITS? | | |
| Marylan | | ince Geor | ge | Lau | reı | | | | | | YES 2 NO |
| | ooklyn Bi | ridge Roa | oad 20707 | | | | | 10g. CITIZEN OF WHAT COUNTRY? | | | COUNTRY? |
| 11. MARITAL STATUS | | NT EVER IN U.S. NAMED 13 | | | | | ORIGIN? (Specify Yes | | | American Indien, | |
| 1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Maxie | | | | | | on, Mexican | Puerto Rican, etc.) | | Black, W | nite, etc. | |
| 3 Widowed 4 | Divorced | | AIT OIL DAILE | | '' | ES PENO | Specify. | | | Specify: | hite |
| | 15. DECEDENT'S EDU | | 16a. DE | CEDENT'S USI | JAL OCCUP | ATION | ina | 16b. KIND OF BU | SINESS/INDUS | STRY | |
| Elamentery/Secon | | College (1-4 or 5 | life | . Do NOT use re | tired.) | most or works | , ng | | | | |
| 9 | | 0 | Ha: | shinat | on Po | st Age | ent | New | spaper | • | |
| 17. FATHER'S NAME | | C | | | | 18. MOT | NER'S NAM | E (First, Middle, Maiden | Surname) | | |
| John C. | Hofmann | , Sr. | | | | Go | ldie | May Chane | у | | |
| 196. INFORMANT'S N | | | | | | | | ute Number, City or Tow | | / | |
| Agnes H | | | | | | | | d. Laurel | , MD | 2070 | / |
| 206 METHOD OF DE | SPOSITION Temetion 3 - Ram | oval from State | 20b. PLACE | OF DISPOSITION | ON (Name o | cemetery, crei | matory or | 20c. LO | CATION - CI | ty or Town, | Stata |
| 4 Donation 5 | | | _ St. Mai | rý's C | athol | ic Ch. | . Cem | etery La | urel, | Hary | land |
| 21 SIGNATURE OF F | UNERAL SERVICE LI | CENSEE | | | 22. NAM | E AND ADDRE | SS OF FAC | | | | ne, Inc. |
| 10 | or. | 10 1 | | | 7601 | Sandy | v Spr | ing Rd. L | | | |
| 23. PART I. Enter | the diseases, or | complications the | t caused the de | ath. Do not | | | | aa cardiac or reap | | | Approximata |
| ahoci | k, or haart fallure. | Liat only one car | se on each line | l. | | | ung, uuun | and on top | indicately district | , | Interval Batwean |
| disease or condi | | Compr | oggion : | anhini | | | | | | | Onset and Death |
| resulting in deati | | | ession a | | La | | | | | | |
| | 100 | 202 10 | (OIT NO A CONSE | OULIVEE OF J. | | | | | | | |
| Sequentially list if any, leading to cause. Enter UNI CAUSE (Disease that initiated eve resulting in deati | | b. DUE TO | (OR AS A CONSE | OUENCE OF: | | | | | | | |
| if any, leading to cause. Entar UNI | | | | , | | | | | | | |
| CAUSE (Disease that initiated eve | | DUE TO | (OR AS A CONSE | OUENCE OF): | | | | | | | |
| resulting in deati | | 4 | | | | | | | | | |
| | | 6 | | | | | | | | | |
| 14 | gnificant condition | | death but not i | resulting in t | ha undari | ying cause | given in f | art I. 24a. WAS AN PERFOI | | | RE AUTOPSY FINDINGS |
| | re of wri | LST | | | | _ | | 1 XX YES : | NO D | | MPLETION OF CAUSE DEATH? |
| | | | | | | | | | | | YES 2 NO |
| | | | | | | | | | | | |
| 25. WAS CASE REFE EXAMINER? | RRED TO MEDICAL | HOSPITAL: | | | | . PLACE OF D | DEATN (Che | k only one) | | | |
| 1 XXES 2 □ | NO | | ER/Outpetient 3 | | THER: | Home 5 🕮 | Keldence 8 | Other (Specify) | | | |
| 27. MANNER OF DEA | | 28a. DATE OF (Month, D | INJURY | 28b. TIME O | F 28c. | INJURY AT WORK? | | 28d. DESCRIBE NOW | INJURY OCCU | RED | dar 11 |
| | 5 Pending Investigation | 11-24 | | 1 | | YES 25 | ₫ % 0 | subject pi sheets | rnnea | uriaei | dry wall |
| 1 Netural | | 28a PLACE (| OF INJURY At he etc. (Specify) | ome, farm, stre | et, fectory, | office | \neg | 28f. LOCATION (Street City or Town, State | end Number of | r Rural Route | Number, |
| 2√X Accident 3 ☐ Suicide | 6 Could not be | building | (checit) | Home- | garaq | е | | | | ridae | Da Tarre |
| 2√ Accident | 6 Could not be determined | building. | | Suicide 4 Homicide Home-garage Home-garage Home-garage Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Table Home-garage Home-garage Table Home-garage Home-garage Home-garage Table Home-garage Home-gar | | | | | | | |
| 2√√√ Accident 3 ☐ Suicide 4 ☐ Homicide | determined | building, | my knowledge de | | t the lime | data and also | e and a P | rinceGeoi | raes. C | | |
| 2 Accident | determined CERTIFYING PHYS | building, | | eath occurred a | | | | | | ounty | ,MD |
| Accident 3 Suleide 4 Homicide 29e. CERTIFIER (Check only one) 2 [| determined CERTIFYING PHYS XMEDICAL EXAMINI | building, | | eath occurred a | | n, death occu | ared at the t | ime, date and place, a | nd due lo lhe | ounty | MD d manner ee stated. |
| 2MA Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 [| determined CERTIFYING PHYS | building, | | eath occurred a | | 29c. LIC | CENSE NUM | ime, date and place, a | nd due to the | couse(e) ar | orth, Day, Year) |
| 2xX Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 [| CERTIFYING PHYS XMEDICAL EXAMINI O TITLE OF CENTIFIE | building, | Examination and by | investigation, | n my opinic | 29c. LIC | ared at the t | ime, date and place, a | nd due to the | ounty | of manner ee stated. |
| 20% Accident 3 Suicide 4 Homicide 29e. CERTIFIER (Check only one) 2 [| CERTIFYING PHYS MEDICAL EXAMINI O TITLE OF CENTIFIE RESS OF PERSON WI | building, | Examination and by | Investigation, | n my opinic | 29c. LIC | CENSE NUM | ime, date and place, a | 29d. DATE: | couse(e) ar signed (MG 1-25- | manner ee stated. |
| 290. CERTIFIER (Check only one) 2 [| CERTIFYING PHYS XMEDICAL EXAMINI O TITLE OF CENTIFIE RESS OF PERSON WITH | building, | SE OF DEATH (IT) | Investigation, | n my opinic | 29c. LIC | CENSE NUM | ime, date and place, a | 29d. DATE: | couse(e) ar signed (MG 1-25- | d manner ee stated. |
| Accident Suicide | determined CERTIFYING PHYS XMEDICAL EXAMINI O TITLE OF CENTIFIE RESS OF PERSON WIT GOLLB, with, Day, Year) | BR On the basic of a R ON THE CAU THE | Examination and by | investigation, i | n my opinic | 29c. LIC | CENSE NUM | ime, date and place, a | 29d. DATE: | couse(e) ar signed (MG 1-25- | d manner ee stated. |

DNMN-18 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Amount after death. Page 6 may be retained by the hospital or attending physician. To THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

SUSAN PROUTY,

M.D.

1990

32 REGISTRAR'S SIGNATURE Julia Daydoon-Kandelle

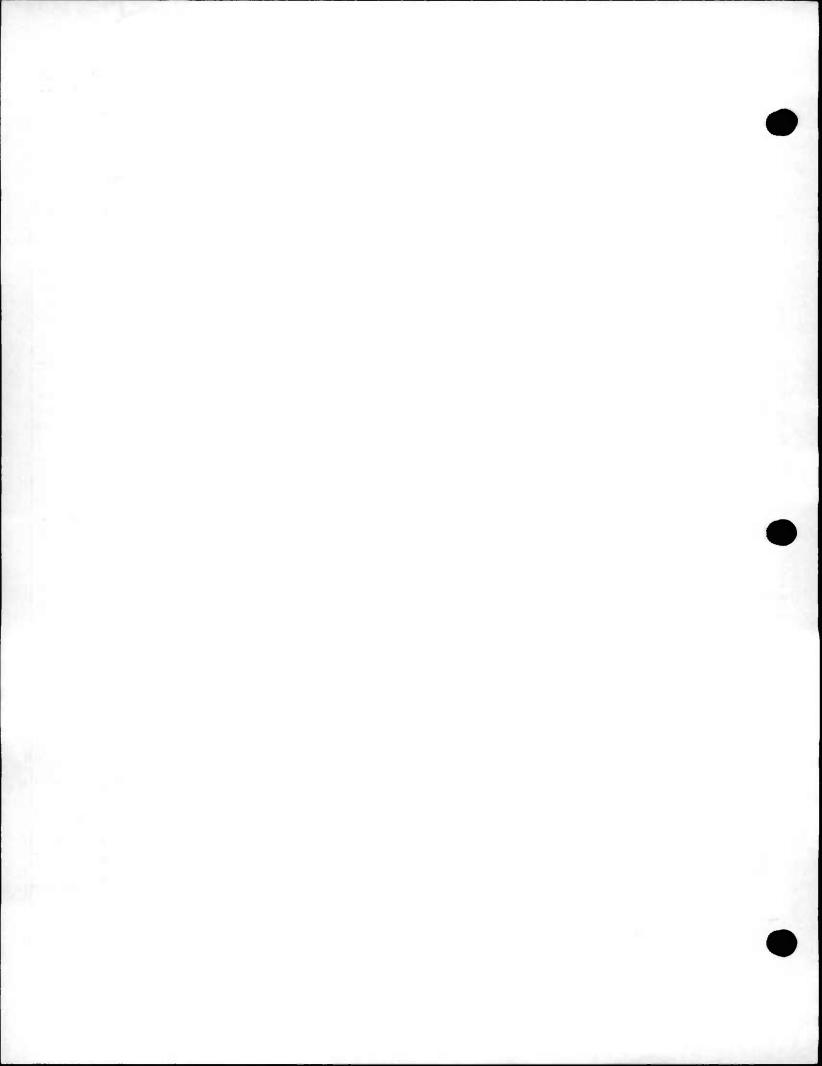
nours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146

| | 1 - STATE REGISTRAR | STATE OF MA | ARYLAND / DEF CERT | PARTMENT OF | | | NTAL HYGIEN | _ | 76 24275 | | |
|---------------------|--|---|--------------------------------------|---|-----------------------------|-----------------------|--|---|--|--|--|
| 3 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. | DATE OF DEATH | DAY YEAR 3. TIME OF DEATH | | | |
| | DENNIE DIXIE | | | | | DE | CEMBER (| 09. 199 | 90 2005 P M | | |
| | 4. SOCIAL SECURITY NUMBER 233 16 9344D | 5. SEX 1 M 2 X F | i. AGE (In yrs. lest birtho 79 YR | MONTHS D | EAR IF UNDER | 24 HRS. 7. MIN. Se | Month, Day, Year) | 1911 W | BIRTHPLACE (State or Foreign Country) est Virginia | | |
| | 9a. FACILITY NAME (If not institution, give s | treet and number) | | 9b. CITY, TO | WN OR LOCATION | | | | | | |
| TOR | CALVERT MEMORIA | L HOSPITA | Γ | PRI | RINCE FREDERICK CALVERT | | | | | | |
| BY FUNERAL DIRECTOR | Maryland Calve | | | aty, town on i | OCATION | | | 10d. INSIDE CITY LIMITS? 1 □ YES 2 凸 N | | | |
| | 835 Lazy Lane | | 101. ZIP CODI 206 | | N OF WHAT COUNTRY? | | | | | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | Never Married 2 Married FORCES? 1 YES 2 NO | | | | | 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Year if yea, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: | | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 +) | | NT'S USUAL OCCU d of work done duri OT use retired.) EWife | PATION og most of worldn | rg . | home | ISINESS/INDUS | STRY | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Lest) John Wesley Sturdivant 18. MOTHER'S NAME (First, Middle, Melden Sumame) Sophia Mae Collins | | | | | | | | | | |
| TO B | 10- INFORMANTE NAME (To COM | | | | | | | | | | |
| | 20a, METHOD OF DISPOSITION 1 ☑ Burial 2 ☐ Cremation 3 ☐ Ram 4 ☐ Donation 6 ☐ Other (Specify) | n Memori | of cometery, cren al Gard | dens | | | - City or Town, State Maryland | | | | |
| | 21. SIGNATURE OF FUNERAL BERVICE LIC | ENSEE | | 22. NA | ME AND ADDRES | SS OF FACILITY | Rausch | Funer | al Home | | |
| | Drawsc | | | 440 |)5 Broo | mes Is | | | Republic Maryla | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or respiratory errest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Candidavas ceular Disease (Fairs) | | | | | | | | | | |
| ATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | | |
| RTIFIC | CAUSE (Disease or Injury thet Initiated events resulting in death) LAST | | | | | | | | | | |
| DICAL CERTIFICATION | | | | | | | | | | | |
| PHYSICIAN: MEL | Gangrene | of left | foot | | | | | | 1 TYES 2 NO | | |
| CIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 86. PLACE OF D | EATH (Check of | only one) | | | | |
| 1YS | 1 YES 2 NO | | ER/Outpatient 3 DC | DA 4 Nursing | Home 6 Re | | Other (Specify) | | | | |
| BY PI | Natural 5 Pending | (Month, Day, Year) INJURY W | | | | NO 264 | a. DESCRIBE HOW | INJURY OCCU | HED | | |
| | 3 Suicide 6 Could not be determined | 2 Accident 3 Suicide 6 Could not be building, etc. (Specify) | | | | | | 261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) | | | |
| COMPLETED | | CIAN: To the best of m | | | | | | | | | |
| BE CC | 2' MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occured at the time, deta and place, and dua to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | |
| 10 B | VILLA A IA | V-Vr | ouce " | 10 | 1 1 | 10 | 101 | 17 | 110/00 | | |

PRINCE FREDERICK, MARYLAND

20678

nd



| 1 | • | REGISTI | RF |
|---|------|-----------|-----|
| Г | 1. D | ECEDENT'S | B N |
| l | | | |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| 1 - STATE REGISTRAR | RYLAND / DEPARTMI CERTIFICA | TE OF DEATH | | REG. NO. | | - | |
|--|---|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE | OF DEATH | | 3. TIME OF DEATH | |
| Everett | D. | Heath | 11- | 18-90 PAY | YEA | 10:30AM M | |
| | | NOER 1 YEAR IF UNDER 24 I | RS. 7. DATE | OF BIRTH | 8. BI | RTHPLACE (State or Foreign | |
| 219-42-9052 1 M 2 D F | 46 YRS. MON | THS DAYS HOURS M | me. | , Day, Year) -17 19 | | U.S. | |
| 9e. FACILITY NAME (If not institution, give street and number) | | CITY, TOWN OR LOCATION | | | 9c. COUNTY O | | |
| Parking lot-Trax Res/Lounge | , , | rincess_An | nie | | Comorc | et County | |
| RESIDENCE OF DECEDENT | | TINCESS AN | IIC | | Somers | et county | |
| 10e. STATE 10b. COUNTY | 10c. CITY, TO | WN OR LOCATION | | | | 10d. INSIDE CITY LIMITS? | |
| Maryland Somerset | Prin | ncess Anne | | | | 1 TYES 2 THO | |
| 10e. STREET AND NUMBER | | 10f. ZIP CODE | | | 10g. CITIZEN (| OF WHAT COUNTRY? | |
| Route 3. Box 234 | | 21853 | | | | U.S. | |
| 11. MARITAL STATUS 12. WAS DECEDENT EV | | 13. WAS DECENDENT OF H | ISPANIC ORIGIN | ? (Specify Yee o | r No- 14. R | ACE — Americen Indien, Bleck, White, etc. | |
| 1 Never Merried 2 Merried IF YES, GIVE WAR (| | If yes, specify Cuben, N 1 ☐ YES 2 ☑ NO | | Hicen, etc.) | | Specify: | |
| 3 Wildowed 4 Ly Divorced | | | | | h | hite | |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | 16a. DECEDENT'S USUA (Give kind of work of | AL OCCUPATION done during most of working red.) | 186 | KIND OF BUSI | NESS/INDUSTR | ry | |
| Elementary/Secondery (0-12) College (1-4 or 5+) | | | | | | | |
| 9 | Waterma | an | | Seafoc | o d | | |
| 17. FATHER'S NAME (First, Middle, Last) | | 18. MOTHER | 'S NAME (First, I | Middle, Maiden S | ırname) | | |
| Everett W. Heath | | Re | becca | Adkir | 1S | | |
| 19a. INFORMANT'S NAME (Type/Print) | | RESS (Street and Number or | | | | · | |
| Rebecca Adkins Heath | Rt. 3, | Box 234 F | rince | ss Anr | ne, mo | 1. 21853 | |
| 20a. METHOD OF DISPOSITION 1 IP Burlel 2 Cremetion 3 Removal from State | 20b. PLACE OF DISPOSITIO | | | | TION — City o | | |
| 4 Donetton 5 Other (Specify) | | iole | | Ori | ole. | Md. | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME AND ADDRESS | | 11 | | | |
| > () 9 11 . () | W00005 | Hinman Fu | | | 14057 | | |
| Jim d. Franco G. | M00295 | Princess | | | | | |
| 23. PART Entar tha diseasa, or complications that ca ahock, or haart fallure. List only one cause | used tha death. Do not a on each iina. | ntar tha mode of dying | , such as card | liac or reapin | etory arreat, | Approximata Intarval Batween | |
| IMMEDIATE CAUSE (Final | | | | | | Onset and Death | |
| disease or condition | sclerotic car | diovascular | diseas | se | | | |
| DUE TO (OR | AS A CONSEQUENCE OF): | | | | | | |
| Sequentially list conditions, 6. | | | | | | | |
| if any, leading to immediate | AS A CONSEQUENCE OF): | | | | | | |
| cause, Entar UNDERLYING CAUSE (Disease or injury | | | | | | | |
| CAUSE (Disease or Injury Due to (OR AS A CONSEQUENCE OF): | | | | | | | |
| that initiated availts | | | | | | | |
| resulting in death) LAST | | | | | | | |
| resulting in death) LAST | ith but not resulting in th | a undariving causa give | en in Part i | 24e. WAS AN A | UTOPSY | 24h WERF ALITOPSY FINDINGS | |
| that initiated availts | ith but not resulting in th | a undariying cauaa givo | en in Part i. | 24e, WAS AN A PERFORM | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| resulting in death) LAST | ith but not resulting in th | a undarlying causa give | en in Part i. | | ED? | | |
| resulting in death) LAST | ath but not resulting in th | a undarlying cauaa givo | en in Part i. | PERFORM | ED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| reaulting in death) LAST d PART II. Other algorificant conditions contributing to dea | ath but not resulting in th | | | PERFORM | ED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PART II. Other algnificant conditions contributing to dea | | 26. PLACE OF DEAT | | PERFORM | ED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PART II. Other algnificant conditions contributing to deal conditions conditions contributing to deal conditions con | | | 'H (Check only or | PERFORM XXES 2 [| IED? □ NO | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | |
| PART II. Other algnificant conditions contributing to deal contribution contributing to deal contribution contributing to deal contribution contributing to deal contribution contributing to deal contribution contributi | VOutpatient 3 DOA 4 URY 28b. TIME OF | 26. PLACE OF DEAT HER: Nursing Home 5 ☐ Resid | "H (Check only or | PERFORM XXES 2 [| Parki | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N} \) NO | |
| reaulting in daeth) LAST DART II. Other algnificant conditions contributing to daes 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXES 2 □ NO 1 □ Inpetient 2 □ ER 27. MANNER OF DEATH 28. DATE OF INJ | VOutpatient 3 DOA 4 URY 28b. TIME OF | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT | H (Check only or ence & Dthe 28d. DE: | PERFORM XXXES 2 [10) 11 (Specify) | Parki | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N} \) NO | |
| PART II. Other algnificant conditions contributing to describe the part of the | VOutpatient 3 DOA 4 CURY 28b. TIME OF INJURY | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 26c. INJURY AT WORK? M 1 YES 2 N | TH (Check only or ence &\D\Dthe | PERFORM XXXES 2 [in (Specify) SCRIBE HOW IN ATION (Street at | Parki | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N} \) NO | |
| PART II. Other algnificant conditions contributing to deal conditions conditions contributing to deal conditions cond | VOutpatient 3 DOA 4 CURY 28b. TIME OF INJURY | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 26c. INJURY AT WORK? M 1 YES 2 N | TH (Check only or ence &\D\Dthe | PERFORM XXXES 2 [10) If (Specify) SCRIBE HOW IN. | Parki | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N}\) NO | |
| PART II. Other algnificant conditions contributing to deal 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXES 2 NO 1 Inpatient 2 ER 27. MANNER OF DEATH XXEgural 5 Pending Investigation 3 Suicide 8 Could not be determined 29a. CERTIFIER 1 CERTIFVING PHYSICIAN: To the heat of Still | UCutpatient 3 DOA 4 DOA 4 DOA 4 DOA 4 DOA 4 DOA 1 DOA | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT WORK? M 1 YES 2 N I, factory, office | in (Check only or ence SCA) the 28d. DE: | PERFORM XXXES 2 [ine) in (Specify) SCRIBE HOW IN CATION (Street ar or Town, State) | Parki JURY OCCURE | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N}\) NO | |
| PART II. Other algnificant conditions contributing to describe the conditions conditions contributing to describe the conditions | URY 28b. TIME OF INJURY URY 28b. TIME OF INJURY JURY At home, farm, street (Specify) | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT WORK? M 1 YES 2 N , factory, office | iH (Check only or ence SCO) the 28d, DE: | PERFORM XXXES 2 [Interpretation of Town, State) PERFORM XXXES 2 [Interpretation of Town, State) | Parki JURY OCCURE of Number or Re | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N}\) NO Ing lot. D ural Route Number, | |
| PART II. Other algnificant conditions contributing to dead and algorithms are algorithms. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH 280. DATE OF INJ. (Month, Day, Y. (Month, Day, Y. 280. PLACE OF INJ. 280. PLACE OF INJ. (Check only one) 280. MEDICAL EXAMINER: On the best of my one) | URY 28b. TIME OF INJURY URY 28b. TIME OF INJURY JURY At home, farm, street (Specify) | 26. PLACE OF DEAT HER: Nursing Home 5 Redd 28c. INJURY AT WORK? M 1 YES 2 N , factory, office | TH (Check only or ence \$\infty\) 28d. DE: | PERFORM XXXES 2 [Interpretation of Town, State) PERFORM XXXES 2 [Interpretation of Town, State) | Parki DURY OCCURE OF THE STATE OF THE STAT | AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXIX YES 2 \(\text{NO}\) NO Ing lot. D ural Route Number, | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 27. MANNER OF DEATH \text{\text{Normal}} \text{\text{Normal}} \text{\text{Sturial}} Date of invarigation Death Dea | URY 28b. TIME OF INJURY URY 28b. TIME OF INJURY JURY At home, farm, street (Specify) | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT WORK? M 1 YES 2 N , factory, office | TH (Check only or ence SQ the ence SQ the ence 28d. DE ence 28d. LOC City and due to the ce at the time, date | PERFORM XXXES 2 [Interpretation of Town, State) PERFORM XXXES 2 [Interpretation of Town, State) | Parki JURY OCCURE Id Number or Re due to the cee | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\sqrt{N}\) NO Ing lot. D ural Route Number, | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? WAYES 2 NO 27. MANNER OF DEATH WX Metural 2 Accident 3 Suleide 4 Homicide 8 Could not be determined 2 Dear Certifier (Check only one) 2 MEDICAL EXAMINER: On the best of my one) 2 MEDICAL EXAMINER: On the best of examination of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 2 Signature of the determined 3 Signature of the determined 3 Signature of the determined 3 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 4 Signature of the determined 5 Signature of the determined 5 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 6 Signature of the determined 7 Signature of the determined 8 Signature of the determined 8 Signature of the determined 8 Signature of the determined of the determined 8 Signature of the determined | URY 28b. TIME OF INJURY IJURY At home, farm, street (Specify) knowledge, death occurred at Instion end/or investigation, in | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT WORK? 1 YES 2 N factory, office the time, date end plece, er my opinion, death occured 29c. LICENS | TH (Check only or ence SQ the ence SQ the ence 28d. DE ence 28d. LOC City and due to the ce at the time, date | PERFORM XXXES 2 [Interpretation of Town, State) PERFORM XXXES 2 [Interpretation of Town, State) | Parki JURY OCCURE Id Number or Re due to the cee | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\text{NO} \) NO Ing lot. D ural Route Number, use(e) end menner ee stated. INED (Month, Day, War) | |
| PART II. Other algnificant conditions contributing to deal 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX | URY (Specify) 28b. TIME OF INJURY At home, farm, street (Specify) DF DEATH (ITEM 27) (Type, Print) | 26. PLACE OF DEAT HER: Nursing Home 5 Reeld 28c. INJURY AT WORK? 1 YES 2 N factory, office the time, date end plece, er my opinion, death occured 29c. LICENS | TH (Check only or ence & Details of the centre of the cent | PERFORM XXES 2 [Interpolate (Specify) SCRIBE HOW IN CATION (Street ar or Town, State) use(e) end menner of end place, and | Parki DURY OCCURE of Number or Ri due to the ceu 29d. DATE SIG | ANALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXXX YES 2 \(\text{NO} \) NO Ing lot. D ural Route Number, use(e) end menner ee stated. INED (Month, Day, War) | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ZATROU's after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Nem 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DHMH-18 Rev 1/89

ITEMS:23 thru 28f per ME G-671 1/25/91 cm

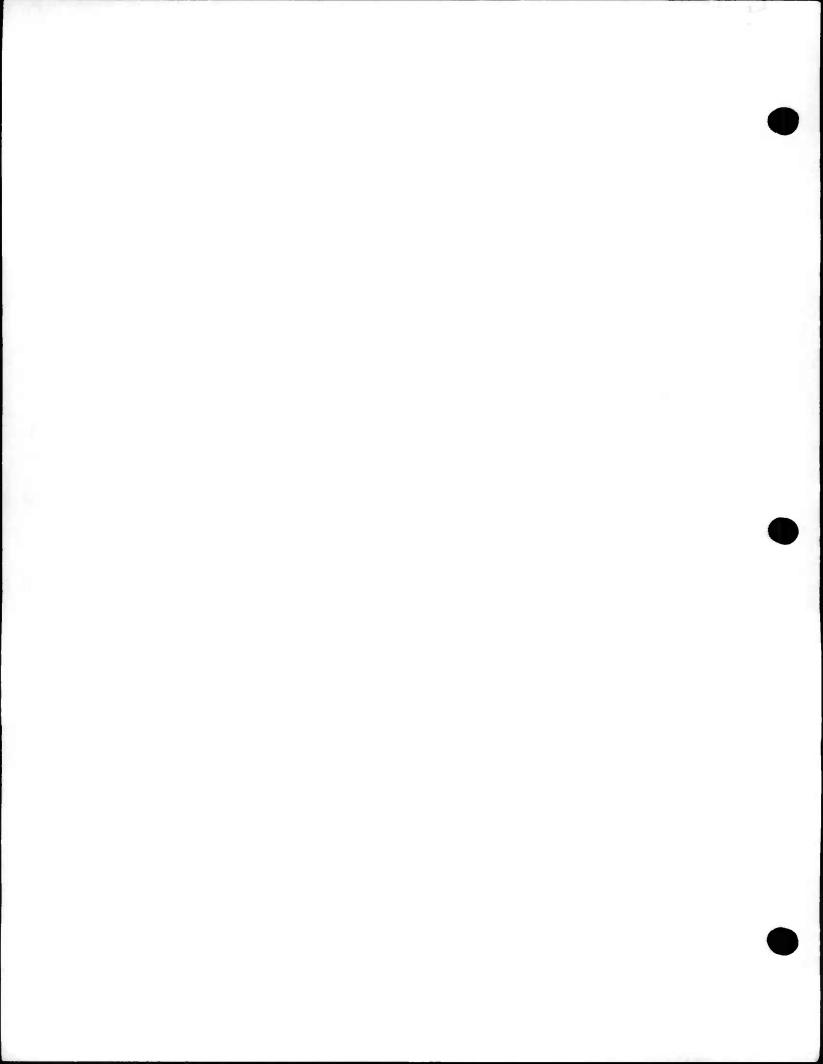
| | 1 - FOR REGISTRAR | STATE OF MARYL | AND / DEPAI CERTIF | RTMENT OF | HEALTH AND | | YGIENE EG. NO. | 90 3 | 3439 | 4 |
|---------------|--|---|---------------------------------|------------------------------|-----------------------------------|----------------------------|-------------------|------------------------|-------------------------------------|------------|
| | 1. DECEOENT'S NAME (First, Middle, I | ast) | | | | 2. DATE OF (| DEATH DAY | YEAR | . TIME OF DEAT | тн |
| | LOTOYA | CANDICE | | HOLLOW | AY | 11 | 23 | 90 | 9:39 | РМ |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 NRS. HOURS MIN. | ?. DATE OF E (Month, Da | | 8. BIRTHPL Country) | ACE (State or Fe | oreign |
| | N/A 9e. FACILITY NAME (If not institution, | X | YRS. | 3 2 | 3200 | | 1-90 | | land | |
| <u>ا</u> س | | | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | 9c. C | OUNTY OF DEA | тн | |
| DIRECTOR | Prince George RESIDENCE OF DECEDEN 100. STATE 100. CO | | | | Cheverly | | P | rince (| George' | S |
| DIRE | 100.00 | PRINCE GEORGES | | fy, town or loca YATTSVIL | | | | | Od. INSIDE CITY LIMITS? YES 2 | |
| A. | 10e. STREET AND NUMBER | | | 10 | H. ZIP COOE | | 10g. | CITIZEN OF WH | A | NO |
| FUNER | 6930 Greenvale | Parkway | | | 20784 | | | USA | | |
| | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMEO | 13. WAS DE | CENDENT OF HISPA | NIC ORIGIN? (S | pecify Yea or No- | - 14. RACE | - Amarican Indi White, atc. | en, |
| В | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DA | ATES | | S 2 NO Speci | | i, aic.j | Specify: | lack | |
| 입 | 15. DECEOENT'S | EOUCATION | 16a. DECEDENT'S | USUAL OCCUPATI | ION | 166 VIN | D OF BUSINESS | /MOUSTRY | STACK | |
| | (Specify only highest (Elementary/Secondery (0-12) | rade completed) College (1-4 or 5+) | (Give kind of life. Do NOT u | work done during m | ost of working | 100. KJN | D OF BUSINESS | INDUSTRY | | |
| 릴 | N/A | Solida (1-4 of 5 +) | N/ | Δ | | | N/A | | | |
| COMPLET | 17. FATHER'S NAME (First, Middle, Las |) | | | 18. MOTHER'S N | AME (First, Middle | | ne) | | |
| BE | Unknown | | | | Debbie | Hollo | wav | | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street | and Number or Rural | | | Zip Code) | | |
| - | Elizabeth Holl | | 6930 | Greeval | e Parkwa | v Hvat | tsville | , MD | 20784 | |
| | 20a. METHOO OF DISPOSITION 1 Depuries 2 Cremation 3 | Ramoval from State | PLACE OF DISPO | SITION (Name of ce | emetery, cremetery or lemorial | | 20c. LOCATION | - City or Town | | |
| | 4 ☐ Donation 5 ☐ Other (Specify) | ETICENDER | 110 | | | | | ver, M | | |
| | Amm | C Keal | 51 | 22. NAME A | ND ADORESS OF FA | J.B | .Jenkin | s Funei | cal Hom | ne |
| | gonorag | | | 14/4 | Landove | r Raod | Lando | ver, M | 2078 | 35 |
| | 23. PART I. Enter the diseases, ahock, or heart fall | or complications that caused are. List only one cause on a | tha daath. Do | not entar tha me | oda of dying, aud | ch aa cardlac | or reapiratory | arreat, | Approxim | ata |
| | IMMEDIATE CAUSE (Final | | | | | | | | Onaat and | |
| | disease or condition reaulting in death) | a. POSITIONAL | ASPHYXI. | Α | | | | | | |
| | | DUE TO (OR AS A | CONSEQUENCE O | OF): | | | | | | |
| ON | Sequentially list conditions, | b,OUE TO (OR AS A | CONSEQUENCE O | IFI: | | | | | - | |
| Ä | if any, laading to immadiata cause. Entar UNDERLYING | | | . ,, | | | | | İ | |
| Ĕ | CAUSE (Disease or Injury that initiated eventa | DUE TO (OR AS A | CONSEQUENCE O | F): | | | | | - | |
| CERTIFICATION | reaulting in death) LAST | d | | | | | | | | |
| | PART II. Other significant cond | itiona contributing to death be | ut not reaulting | in the undarivin | o cause given in | Part I. 24a | . WAS AN AUTOPS | SV 245 W | ERE AUTOPSY F | INDINGS |
| CAL | | - 110-1-11-1 | | | g casos given in | | PERFORMED? | A | MILABLE PRIOR | TO |
| MEDI | | | | | | — ¹ 2 | YES 2 NO | ٥ | F OEATH? | |
| | | | | | | - | | 1) | YES 2 🗌 I | NO |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICA | ı. | | 28. P | LACE OF DEATH (C/ | heck only one) | | | | |
| Sign | EXAMINER? | HOSPITAL: 1 Inpetient 2 XER/Outp | atlant 3 DOA | OTHER: | ne 5 🗆 Residence | | actfv) | | | |
| PHY | 27. MANNER OF DEATH | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIN | IE OF 28c. IN. | JURY AT | T | E HOW INJURY | OCCURED SI | BJECT | FOUN |
| ВУ | 1 Natural 5 Pending 2 Accident Investigat | = 11/77/90 | UNKI | TOTAL TOTAL | YES 2 X NO | MATTRE | SSS H | ED WEDG | E BETW | EEN |
| | 3 Suicide 8 Could not | | At home, ferm, | atrest, factory, offic | ia . | 281. LOCATIO | N (Street and Num | nber or Rural Rou | te Number, | 3 70 000 3 |
| | 4 Homicide determine | HOME | | | | HYATTS | SVILLE, | MARYE | ND, PG | ARKW. |
| | 29a. CERTIFIER (Check only | HYSICIAN: To the best of my knowl | edge, death occurr | red at the time, date | and place, and due | to the cause(a) | and manner as | stated. | | |
| COMPL | one) 2 MEDICAL EXA | MINER: On the basis of examination | and/or investigation | on, in my opinion, o | death occured at the | time, data and | place, and due to | o the cause(a) a | nd manner as a | tated. |
| w II | 29b. SIGNATURE AND TITLE OF CERT | IFIER | | | 29c. LICENSE NU | MBER | 29d. C | DATE SIGNED (M | lonth, Day, Year) | |
| 0 | Mounted De | Chylo | | | OCME | | • | 11-25- | 90 | |
| - | 30. NAME AND ADDRESS OF PERSON | | . , , , , , | | | | | | | |
| | Donald G. Wri | | | n Street | t I | Baltimo | re, MD | 21201 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNA | ATURE | | | | | | | |
| | MOV 3 0 '90 | Julia Davidson-Ra | naesc | | | | | | | |
| | | V | | | | | | | DAMM 4 | 8 Ray 1/89 |

ours after death. Page 6 may be retained by the hospital or attending objection BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

DHMH-18 Ray 1/89

Υ



| DIVISION OF VITAL RECORDS, P.O. BOX 13149, BALLIMORE, MARYLAND 21203-3146 |
|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within Zemours after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunial-transit permit. be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYL | | ENT OF HEALTH AND I | MENTAL HYGIENE REG. NO. | 90 34395 | | |
|--|---|---|---|--|---|--|--|
| 1. OECEOENT'S NAME (First, Midd | le, Last) | | | 2. DATE OF DEATH MONTH DAY | y YEAR 3. TIME OF DEATH | | |
| ISSAC | J. HENRY | | | 11/24/90 | 1.05A M | | |
| 4. SOCIAL SECURITY NUMBER 214-32-7581 | | | UNDER 1 YEAR IF UNDER 24 HRS. THE DAYS HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 08 14 | 6. BIRTHPLACE (State or Foreign Country) Maryland | | |
| 9s. FACILITY NAME (If not institution | | | CITY, TOWN OR LOCATION OF DE | | 9c. COUNTY OF DEATH | | |
| RESIDENCE OF DECEDE | | R | CHEVERLY | | PRINCE GEORGE | | |
| | Prince Georges | | wn or LOCATION pital Heights | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| 10e. STREET AND NUMBER | | | 101. ZIP CODE | I | 10g. CITIZEN OF WHAT COUNTRY? | | |
| I4I7 Addison | Road | | 20743 | | USA | | |
| 11. MARITAL STATUS 1 Never Married 2 Marrie | 12. WAS DECEDENT EVER I | N U.S. ARMED | 13. WAS DECENDENT OF HISPAN If yes, specify Cuban, Maxical | IC ORIGIN? (Specify Yes | or No 14. RACE — American Indian, Black, White, etc. | | |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D | | 1 YES 2 NO Specify | | Specify: Black | | |
| 15. OECEDEN (Specify only higher | T'S EDUCATION est grade completed) | 16s. OECEDENT'S USU (Give kind of work | AL OCCUPATION done during most of working fred.) | 16b. KIND OF BUS | INESS/INOUSTRY | | |
| Elementary/Secondary (0-12) 6th grade | College (1-4 or 5+) | Maintena: | | Privat | ate | | |
| 17. FATHER'S NAME (First, Middle, | Last) | | 18. MOTHER'S NAI | ME (First, Middle, Maiden S | Surname) | | |
| Isaac N. He | | | | Spriggs | | | |
| 198. INFORMANT'S NAME (Type/Pri Delores McKn | | | RESS (Street and Number or Rural F | | | | |
| METHOD OF DISPOSITION | 201 | D. PLACE OF DISPOSITIO other place) | N (Name of cemetery, crematory or | | chts, MD 20743 ATION — City or Town, Stats | | |
| 4 Denation Cher (Special Services) 1 Denation Cher (Special Services) 21 Denature of Funeral Services | f(y) | | ny Memorial Pa | rk Iai | ndover, MD | | |
| Samo | 6 Neut | 1 | 7474 Landover | J.B.Jenl Rd./Landov | kins Funeral Place ver, MD 20785 | | |
| IMMEDIATE CAUSE formal disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b. Die TO (OR AS / | ach lina. CONSEQUENCE OF): CONSEQUENCE OF): | at the mode of dying, such | Auditor reapir | Approximate interval Between Onset and Death | | |
| resulting in death) LAST | | | | | | | |
| 248. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 248. WERE AUTOPSY FINDINGS ANIABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | |
| 25. WAS CASE REFERRED TO MED EXAMINER? | HOSPITAL: | | 28. PLACE OF DEATH (Che | | | | |
| 1 YES 2 NO | 1 Inpatient 2 ER/Out | | Nursing Home 5 - Residence | | Ullim Coolings | | |
| 1 Natural 5 Pendin | (Month, Day, Year) | 1NJURY | 28c. INJURY AT WORK? M 1 YES 2 NO | 26d. DEŞCRIBE HOW IN | JUNY OCCURED | | |
| 3 Suicide 6 Could 4 Homicide determ | not be 28e. PLACE OF INJURY building, stc. (Soe | — At home, farm, atreet | , factory, offics | 281. LOCATION (Street ar City or Town, State) | nd Number or Rural Route Number, | | |
| | G PHYSICIAN: To the best of my know | | | | ner se stated. | | |
| 196. SIGNATURE AND TITLE OF C | | RANA | 29G LICENSE NUM | | 29d, DATE SIGNED (Month, Day, Year) | | |
| 30. NAME AND ADDRESS OF PER | SON WHO COMPLETED CAUSE OF DE | ATH (ITEM 27) (Type, Print | | | 1170 | | |
| NOV 3 0 90 | 32. REGISTRAR'S SIGN Julia Davidson-Ro | | | | | | |

34395

| die | t permit. Pages 1 |
|--------------------------------|--|
| BALTIMORE, MARYLAND 21203-3146 | fiter death. Page 6 may be retained by the hospital or attending physician. r the funeral director, page 5 should be detached for use as the burial-transit permit. Pages oval. |
| BALTIMORE, | ter death. Page 6 may the funeral director, par oval. |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mours after death. Page 6 may be retained by the hospital or at TO THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 1 - STATE REGISTRAR | STATE OF MARYL | | TMENT OF I | | MENTA | L HYGIEN REG. NO. | _ | | |
|--|--|---|--|---|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | E OF DEATH | | | IME OF OEATH |
| WILLIAM BEI | RRY HUCKABE | E | | | NO | | 990 | EAR | 1:15 P M |
| | | (In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | | OF BIRTH th, Day, Year) | 9. | BIRTHPLA | CE (State or Foreign |
| 213-38-2462 | X | 87 YRS. | WONTING CALLS | HOUNS MIN. | | 10 | 903 | ARKA | NSAS |
| 9a. FACILITY NAME (If not institution, give stree | t and number) | | 9b. CITY, TOWN | OR LOCATION OF D | EATH | , . | 9c. COUNTY | OF DEATH | 1 |
| NATIONAL NAVAL N | MEDICAL CEN | | | ETHESDA | | | TNOM | GOME | |
| MARYLAND PRINCE | E GEORGE'S | | , TOWN OR LOCA | | | | | Ι. | LINSIDE CITY LIMITS? YES 2 NO |
| 10e. STREET AND NUMBER | | | 10 | of. ZIP CODE | | | 10g. CITIZEN | OF WHAT | COUNTRY? |
| 5704 31ST AVE | VIIE | | | 20 | 782 | | UNTI | TED S | TATES |
| 11. MARITAL STATUS 1: | 2. WAS DECEDENT EVER II FORCES? 1 TYPES | | | CENDENT OF HISPA | | | | | Amarican Indian. |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR OR D. | ATES | | S 2 NO Specif | | ,, | | Specify: | THYTME |
| 15. DECEDENT'S EOUCAT | ION | - 1950 | USUAL OCCUPATE | ION | 18 | b. KIND OF BU | I SINESS/INDUS | TRY | WHITE |
| (Specify only highest grade con | mpleted) College (1-4 or 5+) | (Give kind of w life. Do NOT us | vork done during m e retired.) | ost of working | | | | | |
| | one | Machini | st | | N | laval G | un Fa | ctory | - D.C. |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | | | | | |
| | E. HUCKABE | E | | LOU | J MCK | ŒE | | | |
| 19a. INFORMANT'S NAME (Type/Print) | (0) | | | and Number or Rural | | | | , | |
| SANDRA H. STRAIN | (Daughter | | | KE ROAD, | MITC | | | | 0721 |
| 20s, METHOO OF DISPOSITION 1 X Burial 2 Crementon /3 Ramova 4 Donatton 5/D Other (Specify) | rom State | o. PLACE OF DISPOS other place) Ort Linco | | | | | CATION — City | | |
| 21. SIGNATURE OF FUNERAL STRVICE LICEN | | JI LINCO | 22. NAME A | NO ADDRESS OF FA | ACILITY | | | | aryland |
| I / M | 14 1. | | Franc | cis Gasch | ı's S | ons Fu | uneral | Hom | e, P.A. |
| 1 Juni | 1 Our | ~ | 4739 | Baltimore | e Av | e. Hy | attsvill | le, N | ld. 20781 |
| 23. PART i. Enter the diseases, or con shock, or heart failure. Lis | nplications that caused it only one cause on e | d the daath. Do n ach lina. | ot antar tha m | ode of dying, suc | ch es ca | rdiac or raspi | ratory arreat | t, | Approximeta intarvai Betwaan |
| iMMEDIATE CAUSE (Fine) disease or condition | | | | | | | | | Onset and Death |
| reaulting in death) a | | ICULAR FI | | LON | | | | | |
| | | | , | | | | | į | |
| Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS / | CONSEQUENCE OF | 7): | | | | | | |
| cause. Entar UNDERLYING | If any, leading to immediate | | | | | | | | |
| CAUSE (Disease or injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| | DUE TO (OR AS A | CONSEQUENCE OF | j: | | | | | | |
| resulting in death) LAST | DUE TO (OR AS A | A CONSEQUENCE OF | 7): | | | | | | |
| | | | | ng causa givan in | Part i. | 24a. WAS AN | | | RE AUTOPSY FINOINGS |
| resulting in death) LAST | | | | ng causa givan in | Part i. | PERFOR | RMED? | AMA | ILABLE PRIOR TO MPLETION OF CAUSE |
| resulting in death) LAST | | | | ng causa givan in | Part i. | | RMED? | COL | ILABLE PRIOR TO |
| resulting in death) LAST | | | | ng causa givan in | Part i. | PERFOR | RMED? | COL | ILABLE PRIOR TO MPLETION OF CAUSE OEATH? |
| PART II. Other algnificant conditions of | contributing to death b | | n tha underlyin | ng causa givan in | | PERFOR | RMED? | COL | ILABLE PRIOR TO MPLETION OF CAUSE OEATH? |
| PART II. Other algnificant conditions of the con | Contributing to death b | out not reaulting i | n tha underlyin 28. F OTHER: 4 □ Nursing Hor | PLACE OF DEATH (C) | heck only o | PERFOR | RMED? | COL | ILABLE PRIOR TO MPLETION OF CAUSE OEATH? |
| PART II. Other algnificant conditions of the con | contributing to death b | put not reaulting is | 28. P OTHER: 4 Nursing Hore URY W | PLACE OF DEATH (C/) me 5 Residence JURY AT ORK? | heck only o | PERFOR | NO NO | AMA COI DF | ILABLE PRIOR TO MPLETION OF CAUSE OEATH? |
| PART II. Other algnificant conditions of the con | Contributing to death b | potent 3 DOA | 28. P OTHER: 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | PLACE OF DEATH (C/ | 6 Oth | PERFORM 1 YES 2 ine) or (Specify) ESCRIBE HOW I | MED? NO NURY OCCUP | AMA COI DF 1 | ILABLE PRIOR TO WHEETION OF CAUSE OCATH? YES 2 NO |
| PART II. Other algnificant conditions of the con | contributing to death b | patient 3 DOA 28b. TIMM | 28. P OTHER: 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | PLACE OF DEATH (C/ | 6 Oth | PERFOR | NJURY OCCUP | AMA COI DF 1 | ILABLE PRIOR TO WHEETION OF CAUSE OCATH? YES 2 NO |
| PART II. Other algnificant conditions of the con | CONTRIBUTING TO death be contributing to death be contributing to death be contributed as the contribution of the contribution | petiant 3 DOA 28b. TIMI [NJI] 7 — At home, farm, a | 28. F OTHER: 4 Nursing Hor URY M 1 | PLACE OF DEATH (C) me 5 | 6 Oth 28d. DE | PERFORM 1 YES 2 one) or (Specify) SCRIBE HOW I CATION (Street or Town, State) | NO NO NUMBER OF OR | AMACOI DF 1 [| ILABLE PRIOR TO WHEETION OF CAUSE OCATH? YES 2 NO |
| PART II. Other algnificant conditions of the con | OSPITAL: To the best of my know | petiant 3 DOA 28b. TIMI [NJ] 7 — At home, farm, a | 28. F OTHER: 4 Nursing Hor URY M 1 I | PLACE OF DEATH (C/) me 5 Residence JURY AT ORK? YES 2 NO Ca a and place, end due | 6 Oth 28d. DE 26f. LO | PERFORM 1 VES 2 1 Y | NJURY OCCUP | AMACOI COI DF 1 [| ILABLE PRIOR TO IPPLETION OF CAUSE OCATH? YES 2 NO Number, |
| PART II. Other algnificant conditions of the con | OSPITAL: To the best of my know | petiant 3 DOA 28b. TIMI [NJ] 7 — At home, farm, a | 28. F OTHER: 4 Nursing Hor URY M 1 I | PLACE OF DEATH (C/) me 5 Residence JURY AT ORK? YES 2 NO Ca a and place, end due | 6 Oth 28d. DE 26f. LO C/h a to the co | PERFORM 1 VES 2 1 Y | NJURY OCCUF | AMA COID OF 1 1 C | ILABLE PRIOR TO IPPLETION OF CAUSE OCATH? YES 2 NO Number, |
| PART II. Other algnificant conditions of the con | CONTRIBUTING to death be seen to death b | patient 3 DOA 28b. TIMI INJI 7 — At home, farm, a riedga, death occurre on and/or investigation | 28. POTHER: 4 Nursing Hore URY M 1 Intreet, factory, officed at the time, dat | PLACE OF DEATH (C/) me 5 Residence JURY AT ORK? YES 2 NO ca a and placa, end du death occured at the | 6 Oth 28d. DE 28d. LO City a to the ca | PERFORM 1 YES 2 or (Specify) CATION (Street or Town, State) RUSSE(a) and mai | NJURY OCCUPANT AND AND AND AND AND AND AND AND AND AND | AMACOI COI COI COI COI COI COI COI COI COI | ILABLE PRIOR TO MPLETION OF CAUSE OCATH? YES 2 NO Number, |
| PART II. Other algnificant conditions of the con | COMPLETEO CAUSE OF DE | petiant 3 DOA 28b. Timi (NJ) (At home, farm, a riedga, death occurre in and/or investigation EATH (ITEM 27) (Type, | 28. POTHER: 4 Nursing Hore E OF 28c. IN URY W 1 intreet, factory, officed at the time, dat n, in my opinion, | PLACE OF DEATH (C) me 5 Residence JURY AT ORK? YES 2 NO ca a and placa, end dud death occured at the 29c. LICENSE NU | 6 Oth 28d. DE 28d. LO City a to the co | PERFORM 1 YES 2 one) or (Specify) ESCRIBE HOW I CATION (Street or Town, State) iuse(a) and mains and place, and place, and place of the state | NJURY OCCUP and Number or iner as stated, d dus to tha c 29d. DATE S CAL CE | AMACOI COI COI COI COI COI COI COI COI COI | ILABLE PRIOR TO MPLETION OF CAUSE OCATH? YES 2 NO Number, |
| PART II. Other algnificant conditions of the con | CONTRIBUTING to death be seen to death b | patient 3 DOA 28b. Timining (A) 28b. Timining (A) 28b. Timining (A) 28b. Timining (A) 28b. Timining (A) (A) (A) (A) (A) (A) (A) (A) | 28. POTHER: 4 Nursing Hore E OF 28c. IN URY W 1 intreet, factory, officed at the time, dat n, in my opinion, | PLACE OF DEATH (C/) me 5 Residence JURY AT ORK? YES 2 NO ca a and placa, end du death occured at the | 6 Oth 28d. DE 28d. LO City a to the co | PERFORM 1 YES 2 one) or (Specify) ESCRIBE HOW I CATION (Street or Town, State) iuse(a) and mains and place, and place, and place of the state | NJURY OCCUP and Number or iner as stated, d dus to tha c 29d. DATE S CAL CE | AMACOI COI COI COI COI COI COI COI COI COI | ILABLE PRIOR TO MPLETION OF CAUSE OCATH? YES 2 NO Number, |



| 90 | 3 | 4 | 3 | 9 | 7 |
|-----|---|---|---|---|---|
| ~ ~ | 9 | 4 | _ | | |

| t. DECEDENT'S NAME (First, Middle, | Last) | | OLITTI | ICATE OF | | | REG. NO. | v | YEAR | 3. TIME OF DEATH |
|--|---|--|--|--|---|---|---|--|---|---|
| L | arry I | æе | He | odaes | | | 11-21-9 | | LAN | 12:10AM |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In | yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DA | TE OF BIRTH 19 | 69 | B. BIRTH | PLACE (State or Foreign |
| 240-33-5764 | 1 💢 M 2 🗌 F | 2: | YRS. | MONTHS DAYS | HOURS MIN. | Aug | rust 14. | | | th Carolin |
| 96. FACILITY NAME (If not Institution, Prince George: | | lospit: | al | | or LOCATION OF D | _ | | 9c. COUNT | TY OF D | EATH |
| Prince George: RESIDENCE OF DECEDEN 10e. STATE 10b. 00 Maryland 10e. STREET AND NUMBER 9076 Cherry 11. MARITAL STATUS 1 M. Never Martiad 2 Maryland 1 M. Never Martiad | | - T-GOD | ~ | CII | CACLTÀ | | | PLIII | ce c | Georges Co. |
| 10e. STATE 10b. CC | | | t0c. CIT | Y, TOWN OR LOCA | TION | | | | | tod. INSIDE CITY |
| Maryland | Prince Geo | rges | | Laurel | | | | | | LIMITS? |
| 10e. STREET AND NUMBER | | -8 | | | . ZIP CODE | | | 10g. CITIZ | EN OF V | VHAT COUNTRY? |
| 9076 Cherry | Lane | | | | 20708 | | | Unit | ed | States |
| tt, MARITAL STATUS | 12. WAS DECED | | | | ENDENT OF HISPA | | | | 4. RACE | - American Indian, |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | 1 NES | | | ecify Cuben, Mexico 2 X NO Specia | | to Ricen, etc.) | | Speci | , while, etc. |
| 15. DECEDENT'S (Specify only highest | EDUCATION grade completed) | | tea. DECEDENT'S (Give kind of life. Do NOT u | S USUAL OCCUPATION | ON ost of working | T | teb. KIND OF BUS | INESS/INDU | STRY | |
| 15. DECEDENT'S (Specify only highest Elementery/Secondary (0-12) 11th grade 17. FATHER'S NAME (First, Middle, Las | College (1-4 or | 5+) | | employed | | | N | lom o | | |
| 17. FATHER'S NAME (First, Middle, Las | 1 | | Otte | ліртоуес | I 48 MOTHER'S N | ME (Ele | st. Middle, Meiden | one | | |
| Jesse | Lee | | Hodges | | Mercie | ME (FIR | л. мюдю, меюел Dee | | Di a | kerson |
| 190. INFORMANT'S NAME (Type/Print) | ree | | | | and Number or Rural | Pourte Al | | | | kerson |
| Mercie D. Hodge | es (mother | •) | | | Lane, Lau | | | | | 8 |
| 200, METHOD OF DISPOSITION | , (inother | | | SITION (Name of ca | | ar Ci | | | | |
| 1 N Buriel 2 Cremetion 3 4 Donation 5 Other (Specify) | Removal from State | 1000 | other place) | Cemeter | | | Fire | No | th | Carolina |
| 21. SIGNATURE OF PUNETIAL SERVE | E LICENSEE | | 10166 | | ND ADDRESS OF F | CILITY | | | | County, |
| College to | the I | 6 | | | | | Latrotti | C Lin | ara | 1 Home |
| IMMEDIATE CAUSE (Final | or complications t ure. List only one of | | | | | _ | | .;Was | h.D | .C. 20011 Approximete Interval Betwee Onset and Dea |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) | Multi | ple in | ijuries | not enter the mo | | _ | enue, N. W | .;Was | h.D | .C. 20011 Approximete Interval Between |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | . Multi DUE | ple in to (or as a control or a control | ch Mna. njuries | not enter the mo | | _ | enue, N. W | .;Was | h.D | .C. 20011 Approximete Interval Between |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b. DUE d. DUE | ple in to (or as a control (or a) control (or a) contr | CONSEQUENCE C | not enter the mo | ode of dyling, suc | ch aa c | enue, N. W | .;Was | h.D | .C. 20011 Approximete Interval Between |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | b. DUE d. DUE | ple in to (or as a control (or a) control (or a) contr | CONSEQUENCE C | not enter the mo | ode of dyling, suc | ch aa c | enue, N. W | AUTOPSY MED? | eh . D | .C. 20011 Approximete Interval Between |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conductions of the conduction o | a. Multi DUE b. DUE c. DUE d. AL | ple in to (or as a control (or a) control (or a) contr | CONSEQUENCE C | not enter the mo | ode of dyling, suc | Part i | 24a. WAS AN PERFOR | AUTOPSY MED? | eh . D | Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions of the conditions of the cause. | a. Multi DUE b. DUE c. DUE d. Illiona contributing | ple intro (or As A (| CONSEQUENCE CONSEQ | OF): OF): In the underlyin 26. P | ode of dying, suc | I Part I | 24a. WAS AN PERFOR | AUTOPSY MED? | eh . D | Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| shock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conductions of the conduction o | a. Multi DUE b. DUE c. DUE d. HOSPITAL: 1 Inpetient | TO (OR AS A (| CONSEQUENCE CONSEQ | OF): In the underlyin 26. P OTHER: 4 Nursing Hor. WE OF 28c. IM. | g couse given in | s Part I | 24a. WAS AN PERFOR 1% XYES 2 | AUTOPSY IMEO? | 24bb DURED | Approximate interval Betwee Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| shock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conductions of the conduction o | a. Multi DUE b. DUE c. DUE d. HOSPITAL: 1 Inpetlet: 1288. DATE (Month) | TO (OR AS A | CONSEQUENCE CONSEQ | DF): DF): In the underlyin 26. P OTHER: 4 Nursing Horn ME OF 28c. NV. JURY WY. M t | g couse given in LACE OF DEATH (C) no 5 Residence JURY AT THE THE THE THE THE THE THE THE THE THE | s Part I | 24a. WAS AN PERFOR 1% XYES 2 | AUTOPSY IMEO? | 24bb DURED | Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| ahock, or heart fell iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the condition of the condition of the condition of the cause. Examiner? ₹25. WAS CASE REFERRED TO MEDIC EXAMINER? ₹26. WAS CASE REFERRED TO MEDIC EXAMINER? ₹27. MANNER OF DEATH t | a. Multi DUE b. DUE c. DUE d. HOSPITAL: 1 Inpetion tition | TO (OR AS A | CONSEQUENCE CONSEQ | DF): DF): In the underlyin 26. P OTHER: 4 Nursing Hon | g couse given in LACE OF DEATH (C) no 5 Residence JURY AT THE THE THE THE THE THE THE THE THE THE | beck only 284.1 | 24a. WAS AN PERFORM 1% XYES 2 | AUTOPSY MED? NO NUMBER OCCUPANT | 24b URED /MV. | Approximate Interval Betwee Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions in the cause of the cause | a. Multi DUE b. DUE c. DUE d. DUE d. HOSPITAL: 1 Inpatient 11 - 28e. DATE (Mont) 11 - 28e. PLAC building PHYSICIAN: To the best | TO (OR AS A | CONSEQUENCE CONSEQ | OF): OF): In the underlyin 26. P OTHER: 4 Nursing Horizont ME OF ME OF ME OF Street, factory, office Coad red at the time, determined to the ti | g ceuse given in LACE OF DEATH (C) ne 5 Residence JURY AT OTHER YES AND Ce | Per I | 24a. WAS AN PERFORM 1 XXYES 2 y one) Ther (Specify) DESCRIBE HOW II TOCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) | AUTOPSY MED? NO NJURY OCC auto and Number occ ent | 24bb LURED / MV. or Rural Land George | Approximete Interval Betwee Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| ahock, or heart fell IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are unitiated events resulting in death) LAST 25. WAS CASE REFERRED TO MEDIC EXAMINER? PART II. Other algnificant conditions are unitiated events resulting in death) LAST 27. WAS CASE REFERRED TO MEDIC EXAMINER? PART II. Other algnificant conditions are unitiated events investigated as a condition of the conditions are unitiated events. The conditions are unitiated events are unitiated events. The conditions are united to th | a. Multi DUE b. DUE c. DUE d. DUE d. HOSPITAL: 1 Inpatient 11 28a. DATE (Mont) 11 28b. PLAC building PHYSICIAN: To the best | TO (OR AS A | CONSEQUENCE CONSEQ | OF): OF): In the underlyin 26. P OTHER: 4 Nursing Horizont ME OF ME OF ME OF Street, factory, office Coad red at the time, determined to the ti | g ceuse given in LACE OF DEATH (C ne 5 Residence JURY AT ORK? YES 20 NO se end place, end du death occured at th | s Part I | 24a. WAS AN PERFORM 1 XXYES 2 y one) Ther (Specify) DESCRIBE HOW II TOCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) | AUTOPSY MEO? NO NUMBER OCCUPANT OCCUPA | 24bb 24bb 24bb 24bb 24bb 24bb 24bb 24bb | Approximate interval Betwee Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |
| ahock, or heart fell iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are under the cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are under the cause of the caus | a. Multi DUE b. DUE c. DUE d. DUE d. HOSPITAL: 1 Inputent 11 - 28e. DATE (Mont) 11 - 28e. PLAC building PHYSICIAN: To the best AMINER: On the basic of | TO (OR AS A | CONSEQUENCE CONSEQ | In the underlying 26. P OTHER: UNITY M 26. P OTHER: W T Street, factory, office COdd red at the time, date | g ceuse given in LACE OF DEATH (C) ne 5 Residence JURY AT OTHER YES AND Ce | heck only Part I Part I S O O 28d. DT 28f. I 64 P to the e time, o | 24a. WAS AN PERFORM 1 XXYES 2 y one) Ther (Specify) DESCRIBE HOW II TOCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) COCATION (Street Company of Town, Street) | AUTOPSY MEO? NO NUMBER OCCUPANT OCCUPA | 24bb 24bb 24bb 24bb 25bb 26bb 26bb 26bb 26bb 26bb 26bb 26 | Approximete Interval Betwee Onset and Dea Dea Onset and Dea Dea Dea Dea Dea Dea Dea Dea Dea Dea |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a few death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

NOV 3 0 90

32. REGISTRAR'S SIGNATURE

Davidson

BALTIMORE, MARYLAND 21203-3146

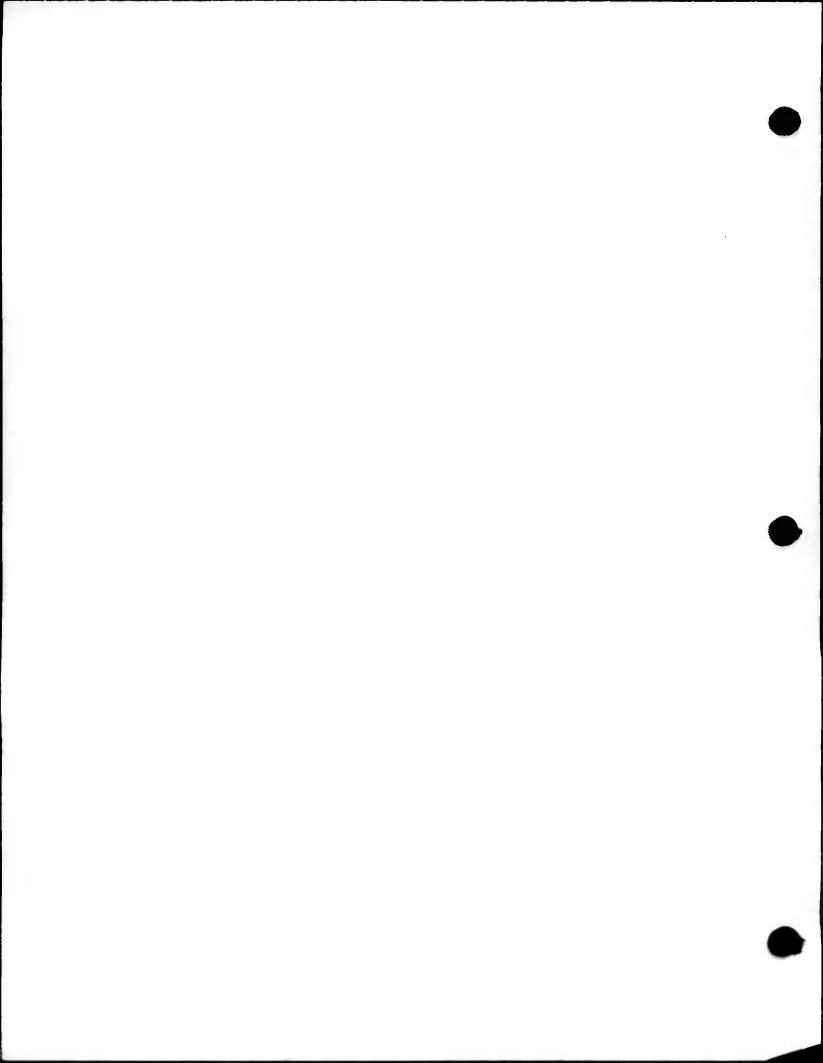
DHMH-16 Rev 1/89

CX

| |) | ges 1, 2, 3 should | |
|--|---|--|---|
| 6, BALTIMORE, MARYLAND 21203-3146 | HYSICIAN; The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | is certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2, 3 should with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | rent, the medical examiner must be notified at once. |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death certificate be executed w | TOTHE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 be. Alled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: if item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

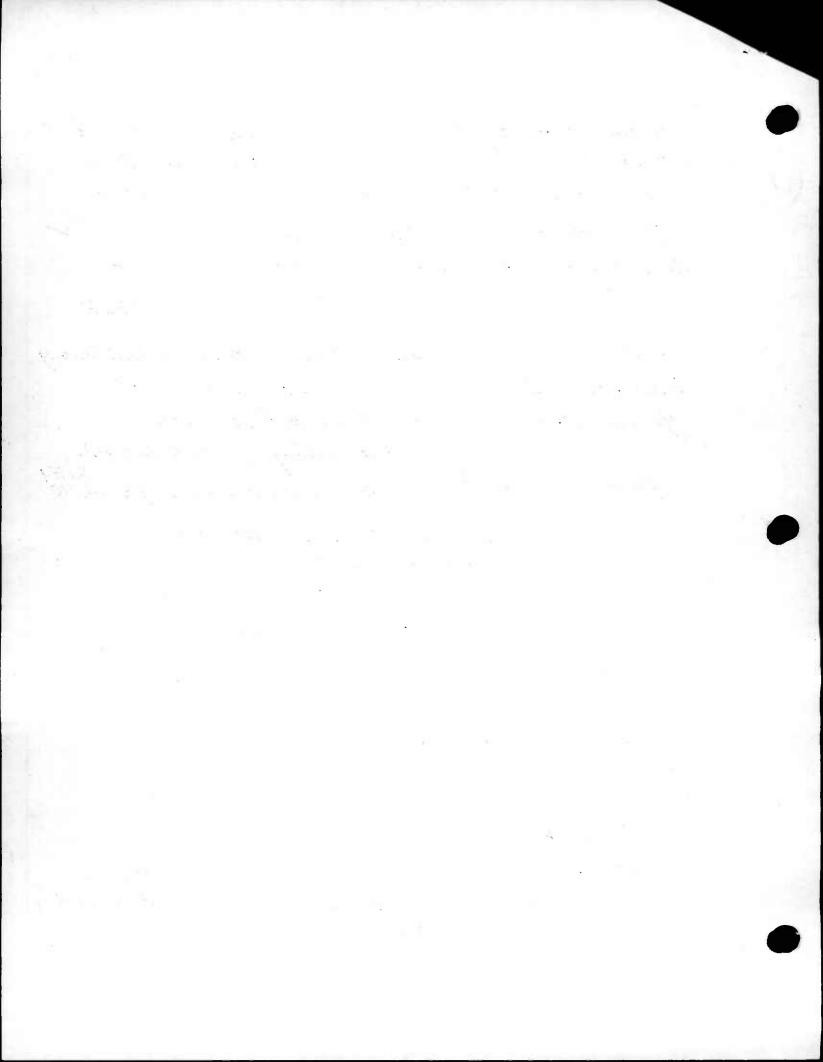
FOR STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. NO. | | |
|-----------------|---|--|---------------------------------------|-------------------------------|-----------------------------|--|------------------------------------|--|
| - 6 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DA | Y YEAR | 3. TIME OF DEATH |
| 3 | JAME | | HILL | | | 11/21/90 | | 5.00AM M |
| | 4. SOCIAL SECURITY NUMBER 250-56-0006 | 5. SEX 6. AGE (fi | | IF UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | | THPLACE (State or Foreign UTH CAROLINA |
| - 1 | 9a. FACILITY NAME (If not institution, give at | | 54 YRS. | OF CITY TOWN | DI LOCATION OF DEA | | | |
| 2 | | | | | OR LOCATION OF DEA | in . | 9c. COUNTY OF | |
| DIRECTOR | PRINCE GEORGES HOS | | | CHEVER | <u>Y</u> | | PRINCE | GEORGE |
| E | 100. STATE 10b. COUNTY MARYLAND PRINC | CE GEORGE'S | 10c. CITY, | LANDO | | | | 10d. INSIDE CITY LIMITS? |
| | 10e. STREET AND NUMBER | E GEORGE 5 | | | | | | 1XXYES 2 □ NO |
| FUNERAL | 1217 NALLEY ROAI |) | | 101 | 2078 | 35 | | F WHAT COUNTRY? S.A. |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | If yes, sp | ecify Cuben, Mexicen. | C ORIGIN? (Specify Yee Puarto Rican, etc.) | or No- 14. R/ | ACE — Americen Indien, ack, White, atc. |
| B√ | 1 Never Merried 2 XXMerried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DA | | 1 🗆 YES | 2 NO Specify: | | Sp | BLACK |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed) | 16a. DECEDENT'S U (Give kind of wo | SUAL OCCUPATION And retired.) | ON all of working | 16b. KINO OF BUS | BINESS/INDUSTRY | , |
| Ä | Elementary/Secondary (0-12) 11th grade | College (1-4 or 5+) | CUSTOD | | | МАТ | NIENANC | F |
| N N | 17. FATHER'S NAME (First, Middle, Last) | • | OODTOD | 17111 | 18 MOTHED'S NAM | E (First, Middle, Maiden | | |
| BE C | JAMES HILL, SR. | | | | | BURROUGH | Surname) | |
| 2 | 190. INFORMANT'S NAME (Type/Print) MARY HILL | | | | | DOVER, MA | | 20785 |
| | 20e. METHOD OF DISPOSITION 1 X uriel 2 Cremation 3 Remo | oval from State | PLACE OF DISPOSIT | TION (Name of cer | metery, cremetory or | | CATION — City or | |
| | 4 Donation 5 Other (Specify) | ester / | LINCOLN | | L CEMETER | | ITLAND, | MARYLAND |
| | PE | Taylo (| | | | RAL HOME, ACE, N.E. | | D.C. 20019 |
| | 23. PART I. Enter the disaeses, or canock, pr heart failure. | complications that caused List only one cause on as | the death. Do no | t anter the mo | da of dying, auch | sa cerdiac or respi | ratory errest, | Approximata Interval Between |
| | IMMEDIATE CAUSE (Final | | | | \bigcirc | 1 (0) | 1 dem | Onset and Death |
| | disease or condition resulting in desth) | a. (6) 110 | 20A | | 2011 | LADIA | 10 | 9 41 |
| _ | _ | DUE TO OH AS A | CONSEQUENCE OF | 3// | | 7 | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate | DUE TO (OR AS/A | CONSEQUENCE OF | 2400 | no V | 4 | | 9 2 |
| <u>8</u> | cause. Enter UNDERLYING CAUSE (Disease or Injury | c. (i) | 10 V | 0 | | | | - Suee |
| ᄩ | that initiated events resulting in deeth) LAST | DUE TO (OR AS A | CONSEQUENCE OF | | | | | 0 |
| E | resulting in death, Exer | d | (Y). | | | | | 3110 |
| | PART II. Other algolificant condition | s contributing to death be | ut not resulting in | the underlyin | g ceuse given in F | Part I. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| EDICAL | | | | | | 1 YES 2 | | COMPLETION OF CAUSE DF DEATH? |
| | | | | | | | ^ | 1 TYES 2 THO |
| ä | | | | | | | | |
| 등 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PI | ACE OF DEATH (Chec | ck only one) | | |
| 10 | 1 U YES 2 UNO | 1 Inpatient 2 - ER/Outp | atient 3 DOA | 4 - Nursing Hon | ne 5 🗆 Residence 8 | | | |
| ا ≼ | | 20- DATE OF IN HIRW | 26b. TIME | | URY AT | 28d. DESCRIBE HOW I | NJURY OCCURED | |
| PHYSICIAN: M | 27. MANNER OF DEATH 1. Natural 8 Pending | 28a. DATE OF INJURY (Month, Day, Year) | INJU | | YES 2 NO | | | |
| B⊀ | 14 Netural 8 Pending 2 Accident Investigation | (Month, Day, Year) 28e. PLACE OF INJURY | - At home, ferm, st | M 1 🗆 | YES 2 NO | 28f. LOCATION (Street | | al Route Number, |
| B⊀ | 14 Netural 8 Pending 2 Accident Investigation | (Month, Day, Year) | - At home, ferm, st | M 1 🗆 | YES 2 NO | 28f. LOCATION (Street of City or Town, State) | | ral Route Number, |
| B⊀ | 14 Neturel 8 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | (Month, Day, Year) 28e. PLACE OF INJURY | — At home, ferm, st | M 1 🗆 | YES 2 NO | City or Town, State) | | el Route Number, |
| B⊀ | 1 Neturel 8 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSI | (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spec | — At home, ferm, st | M 1 | YES 2 NO | City or Town, State) to the ceuse(e) end mer | nner ee atated. | |
| E COMPLETED BY | 1 Neturel 8 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSI | (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Clans). To the best of my knowless: Clans: To the best of my knowless: Clans: To the best of my knowless: | — At home, ferm, st | M 1 | YES 2 NO | City or Town, State) to the ceuse(e) end mer ime, date end piece, en | nner ee atated. | se(e) end menner ee stated. |
| BE COMPLETED BY | 1 | (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Clans): To the best of my knowless: On the basic of examination | At home, ferm, sti | M 1 | YES 2 NO | City or Town, State) to the ceuse(e) end mer ime, date end piece, en | nner se atated, ad due to the ceus | se(e) end menner ee stated. |
| E COMPLETED BY | 14 Netural 8 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINE | (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Special Clans): To the best of my knowless: On the basic of examination | At home, ferm, sti | M 1 | YES 2 NO | City or Town, State) to the ceuse(e) end mer ime, date end piece, en | nner se atated, ad due to the ceus | se(e) end menner ee stated. |



| 1 | FOR STATE REGISTRAR | STATE OF | MARYLAND / DEPAR CERTIF | RTMENT OF H | | | YGIENE EG. NO. |
|---|--|----------|------------------------------|------------------|-------------------|--------------|-------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) NORA IMC | GENE | HURD | | | 2. DATE OF D | EATH DAY |
| | A SOCIAL SECURITY NUMBER | 5 SEY | B ACE //a sum land hirthdays | IE HARRED 4 VEAD | IF HAIDED OF 1900 | T DATE OF D | |

| | nedis i nan | | CENTIF | ICATE OF | DEATH | REG. NO. | | |
|---------------|--|--|-----------------------------------|------------------------------------|-----------------------|---|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | . / | | | 2. DATE OF DEATH MONTH DA | | |
| | NORA MO | | | | | 1.2 3 | | |
| | 215-40-6969 | 5. SEX 6. AGE | (In yrs. lest birthday) | MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | | INTHPLACE (State or Foreign ountry) |
| | 9a. FACILITY NAME (If not institution, give s | | 37 | ah CITY TOWN | OR LOCATION OF D | AUG 05,19 | 9c. COUNTY | TENN. |
| E | | | 21 | , | - | | | LOLL |
| DIRECTOR | CARCOLL CO.G. | | 116 | WES | MINSTE | <i>L</i> - | LOPPE | KULU |
| RE | 10a. STATE 10b. COUNTY | • | | Y, TOWN OR LOC | | | | 10d. INSIDE CITY LIMITS? |
| | | UARD | M | | SVILLE | | | 1 TYES 2 THO |
| FUNERAL | 10e. STREET AND NUMBER | 0 4 TF 0 | | 1 | Ot. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? |
| NE | MARRIOTBUILLE | | | | 21104 | | V: | SA |
| F | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT EVER FORCES? 1 YES | 2 NO | If yes, | specify Cuban, Maxico | NIC ORIGIN? (Specify Yea an, Puerto Rican, etc.) | or No- 14. | RACE - American Indian, Black, White, etc. |
| В | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR I | DATES | 1 🗌 YI | S 2 NO Speci | fy: | | Specify; |
| G | 15. DECEOENT'S EDU | CATION | 18a. DECEDENT'S | | | 18b. KIND OF BUS | SINESS/INDUST | RY |
| ET | (Specify only highest grade Elamentary/Secondary (0-12) | College (1-4 or 5 +) | (Give kind of life. Do NOT u | work done during i se retired.) | nost of working | | | |
| API | 8TH | | FACT | DRUW | OCKER | REVER | ANS AL | POLE FACTORY |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | AME (First, Middle, Maiden | Surname) | |
| BE (| | JOHNSON | | | Re31 | E M. ANI | EESO. | N |
| 5 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Stree | t and Number or Rural | Route Number, City or Tow | | (9) |
| - | THE GITTE 110 | 1.20 | IMARI | 101150 | LIE Rd | 2 Box 1 | 1443 | |
| | 20a. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Rem | ovel from State | b. PLACE OF DISPO other place) | and the same of | emetery, cremetory or | 20c. LO | CATION — City | |
| | 4 Donation 5 Other (Specify) | | SPEINGA | | EMETERY | Syg | ESVILL | E,MP. |
| | .7, 7 | insee . DA | L | 22, NAME | AND ADDRESS OF F | ACILITY / | | 21784 |
| | Harry U | . Haight | | HAMI | TENNERAL | HOHE BEX | 195 Syl | BUILLE, MD. |
| | 23. PART I. Enter the diseases, or abook, or heart failure | complications that cause List only one cause on | ed the death. Do | not entar the n | node of dying, aud | ch as cardiac or reap | ratory arreat, | Approximate |
| | IMMEDIATE CAUSE (Final | | - No. of London | | | A | | Interval Between Onsat and Death |
| | disease or condition reaulting in death) | Coro | A CONSTQUENCE O | mone | ercy | Anust | | |
| | | DUE TO (OR AS | | | | 11. | | |
| NO | Sequentially list conditions, | b. Delale | | rchoz | uso pe | allin | | |
| ATI | if any, leading to immediate cause. Enter UNDERLYING | C CO CO | A CONSEQUENCE O | - 11 | 0 0/2 | 10000 | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events | c. DUE TO (OR AS | A CONSEQUENCE O | nov | > 00 | Jee Je | | |
| Ē | reaulting in death) LAST | _ | entino | ko | nt F | Bulling & | | İ |
| S | | a | Y | , , , , | 76 | | | |
| AL | PART II. Other significant condition | na contributing to death | but not resulting | in the underly | ng cause given in | Part i. 24e. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | - Dia | solls me | eau n | 1 | | 1 YES 2 | SCNO | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | ` | 1 YES 2 NO |
| ä | | | | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. OTHER: | PLACE OF DEATH (C | heck only one) | | |
| YS | 1 YES 2 NO | 1 Inpatient 2 NER/Out | | 4 Nursing Ho | ome 5 - Residence | | | |
| F | 27. MANNER OF DEATH 1 Netural 5 Pending | (Month, Day, Year) | 28b. TIN | JURY V | VORK? | 26d. DESCRIBE HOW I | NJURY OCCURE | ED |
| ВУ | 2 Accident Investigation | 20- 21 405 05 1441 | | | YES 2 NO | | | |
| 8 | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJUR building, atc. (Spi | IY — At home, farm, ecify) | atreet, factory, of | lica | 28f. LOCATION (Street a City or Town, State) | and Number or R | ural Route Number, |
| COMPLETED | | | | | | L | | |
| MPI | (Check only | ICIAN: To the beat of my know | | | | | | |
| 8 | 2 MEDICAL EXAMINE | | | | | | | use(a) and manner as stated. |
| BE | 29b. SIGNATURE AND TITLE OF CONTIFIED | CH S | | | 29c. LICENSE NU | MBER OLL D | 29d. DATE SIG | GNED (Month, Day, Year) |
| 2 | Mary 17 | 7 | | | 13 | 0917 | 1 2 | 12/20 |
| | 30. NAME AND ADDRESS OF PERSON WE | REI 31 | EATH (ITEM 27) (Type | Au C | hor so | treet 1 | woot | min sler |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE Julia De | widson-R | ndell | | | Med (Month, Day, Year) - 13/90 - Min Slen |

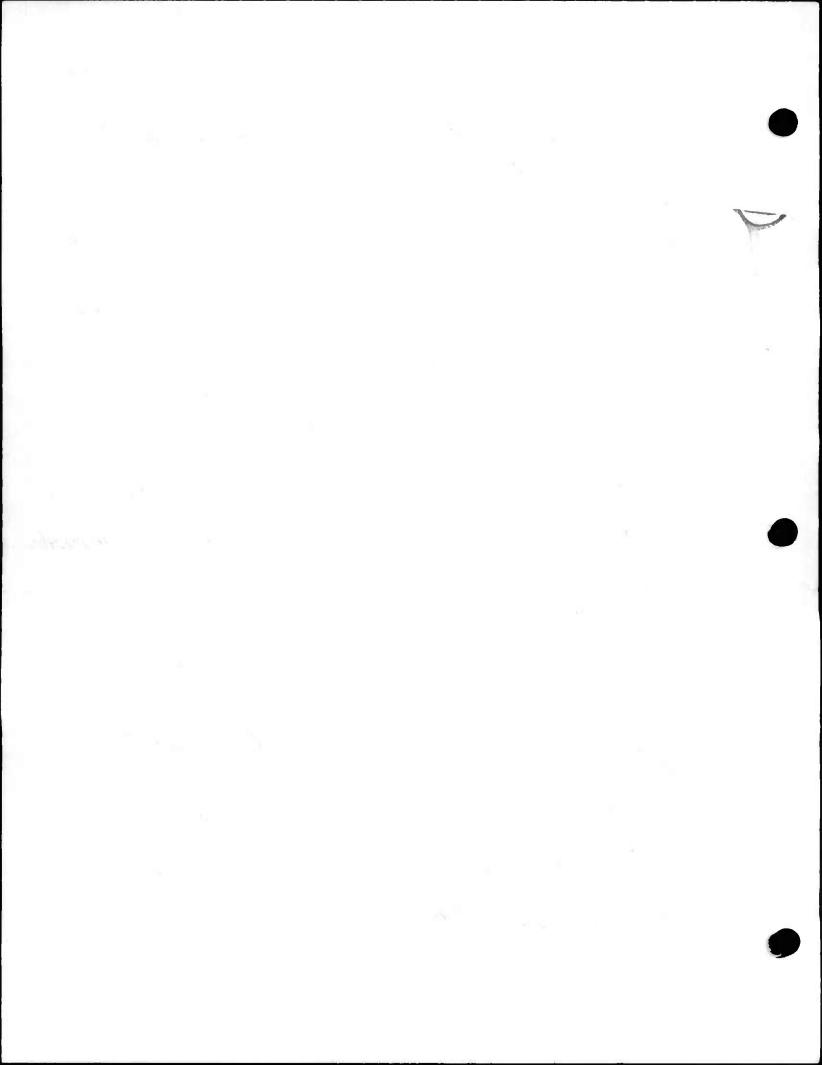


| | REGISTRAR | | CERTIFI | CATE OF | DEATH | F | REG. NO. | | | |
|---------------|--|------------------------------------|-----------------------|---------------------------------|----------------------|---------------------|--------------|----------------|---|----|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 1/ | 1 | | 2. DATE OF MONTH | | VE | 3. TIME OF DEATH | _ |
| | Rose L. | | MOOCI | | | 12 | 1 | 91 | 9:201 | м |
| | 4. SOCIAL SECURITY NUMBER 5. | SEX 6. AGE (I | n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF | BIRTH | 8, 8 | BIRTHPLACE (State or Foreign | _ |
| - 1 | 217 - 03 - 0470 11 | M 2 VF | | MONTHS DAYS | HOURS MIN. | (Month, Di | | | Country) | |
| | | | 4 | | | May 1 | 2, 19 | | aryland | |
| _ | 9e. FACILITY NAME (If not institution, give street | and number) | | 9b. CITY, TOWN C | OR LOCATION OF DI | EATH | | 9c. COUNTY | OF DEATH | |
| ö | Joseph Ritchie Home | 2 | | Baltime | ore City | | | | | |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | _ |
| 1 | 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOCAT | ION | | | | 10d. INSIDE CITY LIMITS? | |
| DIRECTOR | Maryland Anne An | rundal | Glo | n Burni | 0 | | | | 1 YES 2 T NO | |
| | 10e. STREET AND NUMBER | Lunaer | 016 | | , ZIP CODE | | | 10a CITIZEN | OF WHAT COUNTRY? | _ |
| Z I | | | | 1.0 | . 2 0002 | | | log. CITIZEN | OF WHAT COOMINT? | |
| y l | 6422 Lincoln Ct. | | | | 21061 | | | U.S.A | | |
| FUNERAL | | WAS DECEDENT EVER IN FORCES? 1 YES | U.S. ARMED | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (S | pecify Yee | or No- 14. | RACE — American Indian, Black, White, etc. | П |
| ΒX | 25 | IF YES, GIVE WAR OR DA | TES | | 2 NO Specif | | n, etc.) | | Specify: | |
| | 3 Widowed 4 Divorced | | | | 21 | | | | White | |
| 品 | 15. DECEDENT'S EDUCATION | ON | 18e. DECEDENT'S U | SUAL OCCUPATION | ON | 16b, KII | ND OF BUSI | NESS/INDUST | | _ |
| | (Specify only highest grade comp | ollege (1-4 or 5 +) | life. Do NOT usa | ork done during mo retired.) | st of working | | | | | |
| 7 | | | | | | | | | | |
| Σ | 12 | | Reautici. | an | | | auty | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Midd | le, Maiden S | urname) | | |
| BE | Charles J. Robinson | | | | Helen W | alteme | ver | | | |
| | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | OORESS (Street a | nd Number or Rural | | | State, Zip Cod | (e) | _ |
| 2 | Alice Lemmon | | 6422 | | | | | | | |
| | 20e. METHOD OF DISPOSITION | 206 | PLACE OF DISPOSI | Lincoln | Ct. GI | en Bur | | | and 21061 | _ |
| | 1 ☑ Buriel 2 ☐ Cremation 3 ☐ Removal | trom State | other place) | IION (Name or cen | netery, crematory or | | 20c. LOC/ | ATION — City | or Town, State | |
| | 4 Donation 5 Other (Specify) | c | edar Hil | | | | Broc | klvn I | Pk. A.A. MD | |
| | 21. SIGNATURE OF EUNERAL SERVICE DICENSI | EE | | | O AOORESS OF FA | | | | | П |
| | 1 2/2 MEN. | 1 | | | ey Funer | | | | | |
| | 001 2100 | | | 421 C | rain Hwy | . S.E. | , Gle | n Burr | nie, MD 21061 | L |
| | 23. PART i. Enter the diseases, or comp | plications that caused | tha death. Do no | t enter the mo | de of dying, auc | h ee cerdiac | or reepira | atory arrest, | Approximate | |
| - 1 | shock, or heart failure. Liat iMMEDIATE CAUSE (Finel | only one cause on ae | ch line. | | j. | | | | Intervel Between Onset and Deat | |
| | disease or condition | innerel | etic a | 7 h .: . n . | te a | 6 | | | A Contract of | 7 |
| | reaulting in deeth) a | | | CVEL | 111- 6 | ance | | | OMENT | 7. |
| | | OUE IO (OH AS A | CONSEQUENCE OF) | : | | | | | | |
| ᆽᅵ | Sequentially list conditions, b | | | | | | | | | |
| ۲I | if any, leading to immediate | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | | | | |
| ا ق | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | | | | | | | | | |
| <u>E</u> | thet initiated evente | DUE TO (OR AS A | CONSEQUENCE OF) | : | | | | | | _ |
| 声 | reaulting in deeth) LAST | | | | | | | | | |
| CERTIFICATION | d | | | | | | | | | - |
| | PART ii. Other eignificant conditione co | entributing to deeth bu | t not resulting in | the underlying | cause given in | Pert I. 24 | . WAS AN A | UTOPSY | 24b. WERE AUTOPSY FINOINGS | 8 |
| EDICAL | | | | | | | PERFORM | / | AVAILABLE PRIOR TO COMPLETION OF CAUSE | |
| | - | | | | | 1 | YES 2 | □ NO | OF DEATH? | |
| Σ | | | | | | | | | 1 TES 2 NO | |
| HYSICIAN: | | | | | | | | ľ | | |
| ₹ | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF OEATH (Ch | eck only one) | | | | _ |
| <u>ا ي</u> | | SPITAL: | | OTHER: | | | | 1.000 | v | _ |
| ا ≝ | | Inpetient 2 - ER/Outpe | | | a 5 Reeldance | 8 Other (Sp | pecify) | OSPIC | E | |
| E | 27. MANNER OF DEATH | (Month, Day, Year) | 28b. TIME INJU | OF 28c, INJI | URY AT RK? | žad. OESCRI | BE HOW IN. | JURY OCCURE | :0 | |
| B | 1 Naturel 5 Pending 2 Accident Investigation | | | M 1 🗆 Y | ES 2 NO | | | | | |
| - 1 | 3 Suicide a Could not be | 28e. PLACE OF INJURY | At home, term, at | reet, factory, office | | 281. LOCATIO | N (Street an | d Number or R | ural Route Number, | _ |
| | 4 Homicide determined | building, etc. (Special | 'Y) | | | City or To | wn, State) | | | |
| щ | 29e. CERTIFIER | | | | | | | | | _ |
| <u> </u> | (Check only | : To the beat of my knowle | | | | | | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: On | the basis of extimination | end/or investigation. | , in my opinion, de | eath occured at the | time, date end | place, end | due to the cer | use(e) end menner ee stated. | |
| | 296. SIGNATURE AND TITLE OF CERTIPLES | - // | | | 29c. LICENSE NUM | | | | | _ |
| BE | 1,115 100 | melen. | | | DIE! | -C- | | ANG. DATE SIG | INED (Month, Day, Year) | |
| 0 | June jou | 1 | | | 1103 | >07 | | 1 / 2 | 1/70 | |
| | 30. NAME AND ADDRESS OF PERSON WHO CO | MPLETED CAUSE OF DEA | | | مر ا | | / | 10 | (1) - 2-5 | |
| | PAUL K. | 200106 | 1000 90 | 10 CA | TIM ALL | 包 | XUZ | s. M | ובעוצ עו | |
| - 1 | 31. ONTHER HOSE STORE GUND | LALANSON AND VIGNA | TORE | | | , - | - V - F | | | |
| | 111111111111111111111111111111111111111 | | | | | | | | | |

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the property. Age 6 may be retained by the hospital or attending physician and completely filled in by the tuneral director, page 5 should be detached for use as the burist-transf be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

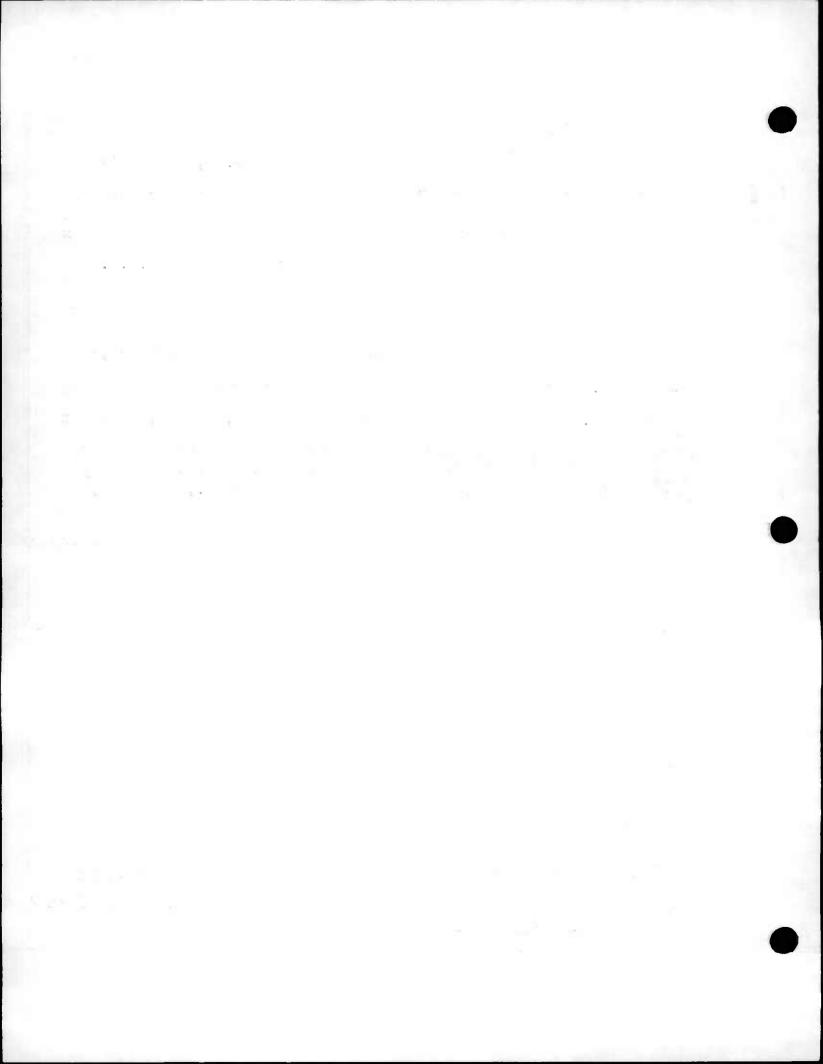


TO BE COMPLETED BY FUNERAL DIRECTOR

| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146 |
|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 nours after death. Page 6 may be retained by the hospital or attending physician. |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pa be filled within 72 hours after death with the State Debt, of Health and Mental Hyglene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEI CERTIFICATE OF DEATH REG. NO. | | 01101 |
|--|---------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH | | 3. TIME OF DEATH |
| 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH | | O A M BIRTHPLACE (State or Foreign |
| 36 [-16-1660 1 M 2 XF 75 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 98. FACILITY NAME (If not institution, give street and number) 99. FACILITY NAME (If not institution, give street and number) | 1915 | Ohio |
| Anne Arundel Medical Center Annapolis | 9c. COUNTY | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION | anne | Arundel |
| Maryland Anne Arundel Arnold | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| 10e. STREET AND NUMBER 10f. ZIP CODE | 10g. CITIZEN | OF WHAT COUNTRY? |
| 1448 Grand View Road 21012 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specity V.) | | S.A. |
| 1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Mexican, Puerlo Rican, etc.) | | RACE — Americen Indien, Black, White, etc. Specify: |
| 3 Wildowed 4 Divorced | | White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4 or 5+) 16b. KIND OF 8I (Give kind of work done during most of working life. Do NOT use retired.) | JSINESS/INDUST | RY |
| 4 Teacher Pub. | lic Sc | hools |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Meide, Meide) | n Surname) | |
| Joseph S. Truax Roxie Truex 196. INFORMANT'S NAME (TyperPrint) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or To | wn State Zin Cod | (e) |
| Chester A. Harriman 1448 Grand View Road, Ar | | |
| 20c. Land Disposition 20c. Land Disposition 20c. La | OCATION — City | or Town, State |
| Lakemont Cemetery D. | avidso | nville,MD |
| Taylor Funeral Char | - | |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or res | Annap | Olis,MD |
| ahock, or heart fallure. List only one cause on each line. | matory arrest, | Intarval Batwaan Onset and Daath |
| disease or condition a. Malignant Lymphome | | 2 years |
| DUE TO (OR AS A CONSEQUENCE OF): | | , |
| Sequentially list conditions, ff any, leading to immediate Due to (or as a consequence of): | | |
| CAUSE (Disease or Injury | | |
| that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | |
| d. | | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS A PERFO | N AUTOPSY PRMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO |
| 1 T YES | 2 🗌 NO | OF DEATH? |
| | | 1 TES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | |
| 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Nursing Home 5 Residence 8 Other (Specify) | | |
| 1 Natural 5 Pending (Month, Day, Year) INJURY WORK? | INJURY OCCURE | :0 |
| 3 Suicide 6 Could not be 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | ural Route Number, |
| 4 Homicide determined | <u> </u> | |
| 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(e) end money one) 2 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the ceuse(e) end money one) | | use(e) and manner se stated |
| 296. SIGNATURE AND TITLE OF CERTIFIED 29c. LICENSE NUMBER | | GNED (Month, Day, Year) |
| 77112 11 TO 1111 MIN | N 13 | 1-1- |
| CUSCO W COULD MD D16354 | 12 | 12/90 |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ENSER W. COLE III 51 FRANKLIN ST ANNA | Polis | Md 2140 |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 yours after death. Page 6 may be retained by the hospital or attend |
|---|
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: It liem 28 is marked, or liem 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

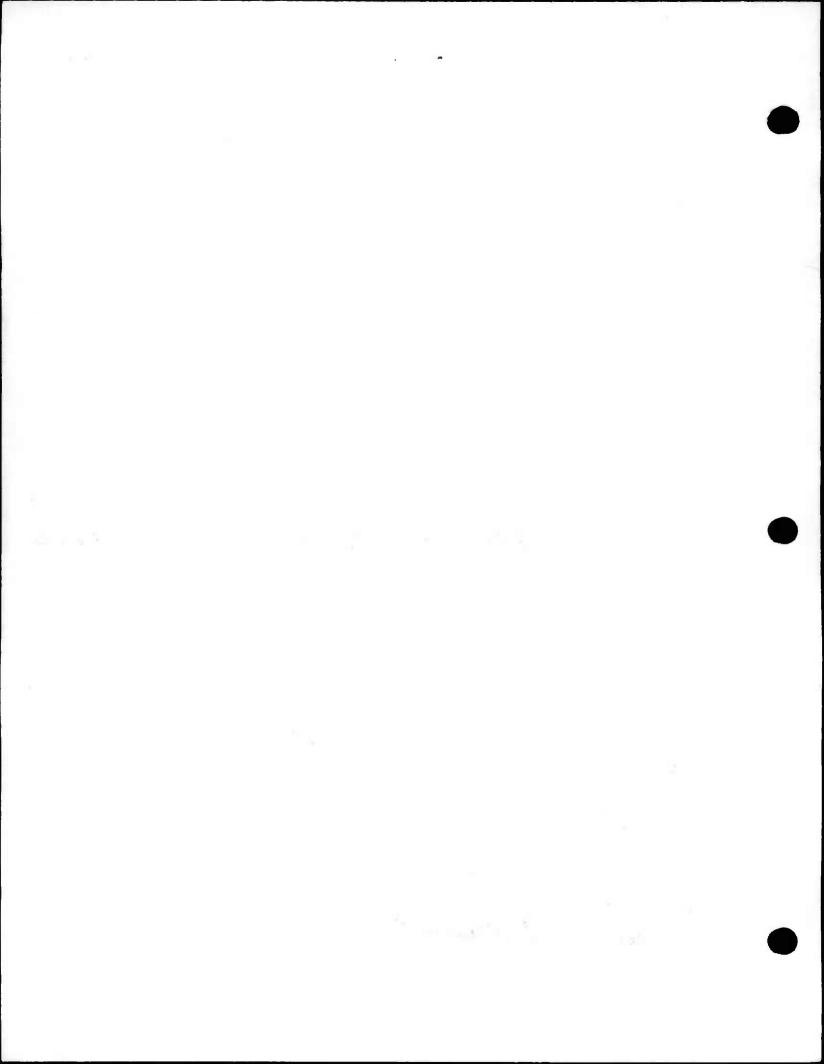
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | | CERTIFIC | CALL | F DEATH | F | REG. NO. | | | |
|--|---|---|--|---|--|--|---|----------------------------------|--|
| 1. DECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF | DEATH | | YEAR | 3. TIME OF DEATH |
| William B. Hughe | 2 0 | | | | MONTH | 30 | 1990 | 7.5 | ∴M. |
| 4. SOCIAL SECURITY NUMBER 5. SI | | in yrs. last birthday) | IF UNDER 1 YE | AR IF UNDER 24 HRS. | 7. DATE OF | BIRTH | | BIRTHP | PLACE (State or Foreign |
| 307-46-2534 X | KM 2 □ F 4 | 6 YRS. | IONTHS DA | AS HOURS MIN. | (Month, D | ay, Year) -1941 | | Country, | |
| Se. FACILITY NAME (If not institution, give street an | | | 9b. CITY, TO | YN OR LOCATION OF DE | | 1 7 7 7 | 9c. COUNT | _ | |
| 2353 Maytime Dr | ive | | Gamb | rills | | | AA (| CO | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, CITY. | TOWN OR LO | CATION | _ | | | Т | 10d. INSIDE CITY |
| A A . | 30 | | | | | | | ı | LIMITS? |
| MD AA | CO | l Gai | nbril | 10f. ZIP CODE | | | 10a. CITIZI | | HAT COUNTRY? |
| 2353 Maytime Dr | ive | | | 21054 | | | USI | | |
| 11. MARITAL STATUS 12. V | WAS DECEDENT EVER I | | | DECENDENT OF HISPAN | | | or No— 1 | 4. RACE | - American Indian, White, etc. |
| 1 Never Merried 2 Married 3 Widowed 4 Olvorced | YES, GIVE WAR OR D | ATES | | r, specify Cuban, Mexica YES 2 NO Specify | | in, wic.) | | Specify | y: |
| 15. DECEDENT'S EDUCATION (Specify only highest grade comple | d eted) | 18e. DECEDENT'S U | SUAL OCCUP | PATION g most of working | 18b. KI | ND OF BUSI | NESS/INDU | | ite |
| | lege (1-4 or 5+) | 100 | | - | | ٦ | | - 4- | |
| | yrs | Analys | t | | | Gover | | 110 | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | | | iumame) | | |
| William H. Hugh | es | | | | e Jor | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | eet and Number or Rural I | | | | | 01051 |
| Marlene A. Hughe | S | 2353 | Mayt | cime Dr. | Gaml | oril. | LS, l | Md a | 21054 |
| 20e. METHOD OF DISPOSITION 1: Buriel 2 Cremetion 3 Removal file 4 Donation 5 Other (Specify) | rom State | other place) | | of cemetery, cremetory or | | | ATION — C | • | · |
| 21. SIGNATURE OF PUNETIAL PRINCE LICENSE | M | d Veter | ans (| E AND ADDRESS OF FA | CILITY | ICroi | Insv: | | e Md |
| · Date I a | UL | | | desty Fu | | | | | 14.1 04.11.04 |
| 23. PART i. Enter the diseases, or compl | icationa that cause | d the death. Do no | ot antar the | moda of dving. suc | h as cardia | c or reapir | atory arre | at. | Md 21401 |
| ahock, or heart fallure. List of | only one causa on a | ach lina. | | | | | 100 | | intarval Batween Onsat and Daath |
| iMMEDIATE CAUSE (Final disease or condition | Mitade | To Park | 71 | ¿ Cance | ۸. | | | | Chaat and Dawth |
| resulting in death) a | | CONSEQUENCE OF | | Carra | | | | | O months |
| 9 | DOE TO (OR AS A | CONSEQUENCE OF | | | | | | | |
| Sequantially list conditions, b | DUE TO (OR AS | CONSEQUENCE OF | | | | | | | |
| If any, leading to immediate cause. Enter UNDERLYING | | | | | | | | | + |
| | | | | | | | | | |
| CAUSE (Disease or injury | DUE TO (OR AS | A CONSEQUENCE OF) | : | | | | | _ | |
| cause (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE OF) | : | | | | | _ | |
| that initiated events | DUE TO (OR AS | A CONSEQUENCE OF) | : | | | | | | |
| that initiated events | | | | lying causa given in | Part I. 2 | 4a. WAS AN | | 24b. | WERE AUTOPSY FINDINGS |
| that initiated events resulting in death) LAST | | | | lying causa given in | | 4a. WAS AN PERFOR | MED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| that initiated events resulting in death) LAST | | | | lying causa given in | | PERFOR | MED? | 24b. | AVAILABLE PRIOR TO |
| that initiated events resulting in death) LAST | | | | lying causa given in | | PERFOR | MED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other algnificant conditions col | ntributing to deeth I | out not reaulting in | the under | lying causa given in | _ 1 | PERFOR | MED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other aignificant conditions could be seen to | | out not resulting in | other: | | neck only one) | PERFOR | MED? | 24b. | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other aignificant conditions could be seen to | SPITAL: Inpetient 2 - ER/Out 28e. OATE OF INJURY | petient 3 DOA | OTHER: | e. PLACE OF DEATH (Ch Home 5 Presidence | neck only one) 8 □ Other (3 | PERFOR | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other algnificant conditions condit | ntributing to deeth I | out not resulting in | OTHER: | 8. PLACE OF DEATH (Ch | neck only one) 8 □ Other (3 | PERFORI | MED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other algnificant conditions condit | SPITAL: Inpatient 2 ER/Out 280. DATE OF INJURY (Month, Day, Year) 280. PLACE OF INJURY | petient 3 DOA 28b. TIME | OTHER: OF 286/RY M 1 | Home 5 Reeldence: NURY AT YES 2 NO | 8 Other (S | PERFORI YES 2 Specify) RIBE HOW IN | JURY OCC | UREO | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PART II. Other algnificant conditions collections and conditions collections are set of the conditions collections. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 1 1 27. MANNED-OF DEATH 1 Netural 5 Pending Investigation | SPITAL: Inpetient 2 ER/Out 28e. OATE OF INJURY (Month, Day, 'ver) | petient 3 DOA 28b. TIME | OTHER: OF 286/RY M 1 | Home 5 Reeldence: NURY AT YES 2 NO | 8 Other (S | PERFORI | JURY OCC | UREO | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PART II. Other algnificant conditions collections and conditions collections. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | SPITAL: Inpatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, 'ber) 28e. PLACE OF INJUR building, etc. (Spe | petient 3 DOA 28b. TIME INJU Y — At home, farm, st | OTHER: 4 Nursing OF RPY M 1 irreet, factory, | Home 5 Reeldence INJURY AT WORK? YES 2 NO | 8 Other (3 28d. DESCF City or | PERFORI YES 2 Specify) RIBE HOW IN ION (Street a Town, State) | MED? | UREO or Rural F | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| that initiated events resulting in death) LAST DART II. Other algnificant conditions co | SPITAL: Inpatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Spe | petient 3 DOA 28b. TIME INJU Y — At home, farm, st | OTHER: 4 Nursing OF 286 RPY 1 | Home 5 Reeldence : INJURY AT WORK? YES 2 NO office | 8 Other (3 28d. DESCF City or | PERFORI YES 2 Specify) RIBE HOW IN ON (Street a fown, State) | MED? | UREO or Rural R | AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PART II. Other aignificant conditions could be conditioned by the conditions could be conditioned by the conditions could be conditioned by the conditions could be conditioned by the conditions could be conditioned by the conditions conditions could be conditioned by the conditions con | SPITAL: Inpatient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Spe | petient 3 DOA 28b. TIME INJU Y — At home, farm, st | OTHER: OTHER: OF Norsing OF | Home 5 Reeldence : INJURY AT WORK? YES 2 NO office | 8 Other (S 28d. DESCF City or | PERFORI YES 2 Specify) RIBE HOW IN ON (Street a fown, State) | IJURY OCCI and Number of | UREO or Rural R | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, 2) and menner ee stated. (Month, Dey, Year) |
| PART II. Other algnificant conditions condit | SPITAL: Inpetient 2 = ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Spe | patient 3 DOA 28b. TIME INJU Y — At home, farm, st city) | OTHER: 4 Nursing OF 286 RPY M 1 ireet, factory, in my opini | Home 5 Reeldence INJURY AT WORK? YES 2 NO office date end place, and due on, death occurred at the | 8 Other (S 28d. DESCF City or | PERFORI YES 2 Specify) RIBE HOW IN ON (Street a fown, State) | IJURY OCCI and Number of | UREO or Rural R | AWALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, |
| that initiated events resulting in death) LAST DART II. Other algnificant conditions co | SPITAL: Inpetient 2 ER/Out 28e. OATE OF INJURY (Month, Day, Year) 28e. PLACE OF INJURY building, etc. (Spe | petient 3 DOA 28b. TIME INJU Y—At home, farm, st cify) viedge, death occurred on end/or investigation | OTHER: OTHER: OF 286 RY M 1 irreet, factory, in my opini | Home 5 Reeldence : INJURY AT WORK? YES 2 NO office date end place, and due on, death occured at the | 8 Other (S 28d. DESCF 28f. LOCATI City or to the cause time, date or | PERFORI YES 2 Specify) RIBE HOW IN TOWN (Street a Town, State) (e) end mennd place, end | IJURY OCCI and Number of the state of due to the 29d. OATE J 2 | UREO or Rural R od. o ceuse(e | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, 2) and menner ee stated. (Month, Day, Year) 2 - 1990 |



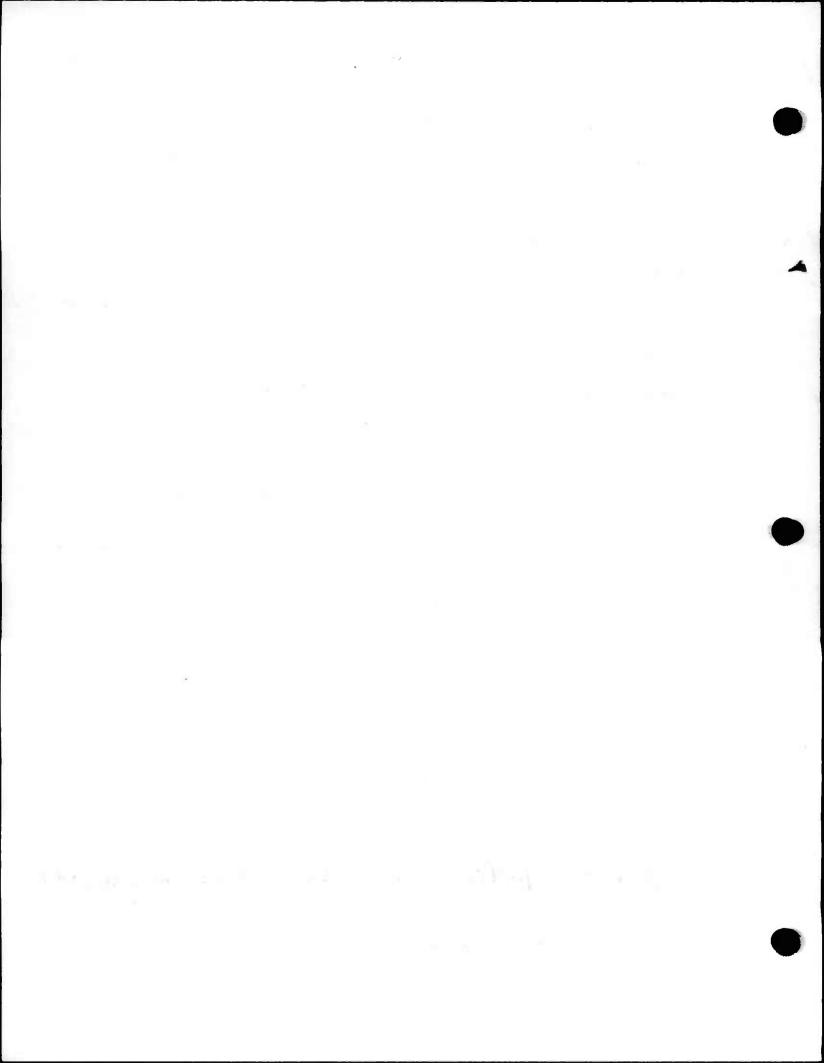
ges 1, 2, 3 should

| | DIRECTOR | |
|---------|------------|--|
| | Y FUNERAL | |
| 0 01111 | OMPLETED B | |
| 0 10 | TO BE C | |
| | | |
| | | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARY | | MENT OF HEALTH AN | D MENT | AL HYGIEN | | |
|--|---|--|---|----------------|-------------------|------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | TE OF DEATH | | 3. TIME OF DEATH |
| ELON JEROM | E | HANLON | 1 | DEC | | 6, 1990 | O 0923 A M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE | | UNDER 1 YEAR IF UNDER 24 H | RS 7 DAT | E OF BIRTH | a. e | BIRTHPLACE (State or Foreign |
| 108-22-6973 90. FACILITY NAME (If not institution, give s. | | Z YRS. | D. CITY, TOWN OR LOCATION OF | | NE 11, | 1928 v | country) ansmills NI |
| KIMBROUGH ARMY CO | | | FT. MEADE | F DEATH | | | 10.25 |
| RESIDENCE OF DECEDENT | NATORVITI TIOC | ,,, | FI. MEADE | | | ANNE A | ARUNDEL |
| 10e. STATE 10b. COUNTY | | 10c. CITY, T | OWN OR LOCATION | | | | 10d. INSIDE CITY |
| NY Jeff | erson | Car | thage | | | | LIMITS? 1 ☐ YES 2√ NO |
| 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | 10g. CITIZEN | OF WHAT COUNTRY? |
| Rt. 2, Box 232 | Pennock R | oad | 13619 | | | USA | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 X YES | IN U.S. ARMED | 13. WAS DECENDENT OF HI | SPANIC ORIG | SIN? (Specify Yes | or No- 14. I | RACE — American Indian, Black, White, atc. |
| 1 Never Merried 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR I | | If yes, specify Cuban, Me | | o Hicen, etc.) | | Specify: White |
| | | | | | | | |
| 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16a. DECEDENT'S US (Give kind of work | UAL OCCUPATION done during most of working tired.) | 16 | Bb. KIND OF BUS | INESS/INDUST | RY |
| Elementery/Secondary (0-12) | College (1-4 or 5 +) | | , , , , , , , , , , , , , , , , , , , | | 77.0 | _ | |
| | | Master | | | US Air | | e |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | , Middle, Malden | | |
| Frank Hanlon 19a. INFORMANT'S NAME (Type/Print) | | | | | la Wag | _ | |
| | - | | DRESS (Street and Number or R | | | | |
| Elon J. Hanlon | | 1462 | <u>Berger Stre</u> | et. | | | |
| 20a. METHOD DF DISPOSITION | oval from State | Offier blace) | on (Name of cometer), crematory 1s Cemetery | | | CATION — City of | or Town, State |
| 21. SIGNATURE OF EUNERAL SERVICE LIG | | | 22. NAME AND ADDRESS O | F FACILITY | | | |
| Dott 4 | Most h | | Hardesty F | 'uner | al Hom | ne, P. | Α. |
| 22 PART I February at a discontinuo | Cores -c | | 851 Annapo | lis | Road, | Gambr | ills,MD |
| 23. PART i. Enter the diseases, or cahock, or haart fallure. I | omplications that cause List only ona cause on a | ed tha death. Do not each line. | entar the moda of dying, | auch as ca | rdiac or respli | ratory arreat, | Approximata interval Batwaen |
| IMMEDIATE CAUSE (Final | | | | | | | Onaat and Daath |
| disease or condition resulting in death) | LUNG CA | NCER | | | | | 6 MOS. |
| | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| Sequantially list conditions. | | Y ARTERY D | ISEASE | | | | |
| if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS | A CONSEQUENCE OF): | | | | | |
| CAUSE (Disease or Injury | | RY FIBROSI | S | | | | |
| that initiated avents reaulting in death) LAST | DUE TO (OH AS | A CONSEQUENCE OF): | | | | | |
| | l | | | | | | |
| PART ii. Other aignificant condition | a contributing to death i | but not resulting in t | ha underlying cause giver | in Part i. | 24a. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| | | | | | PERFOR | MED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | 1 TYES 2 | M NO | OF DEATH? |
| | | | | | | | 1 TYES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 28. PLACE OF DEATH | (Charles and a | 1 | | |
| EXAMINER? 1 YES 2 NO | HOSPITAL: | | THER: | | | | |
| 27. MANNER OF DEATH | 1 X Inpatient 2 ER/Out | 28b. TIME O | Nursing Home 5 Reelder F 28c, INJURY AT | | | | |
| 1 Netural 5 Pending | (Month, Day, Year) | INJURY | WORK? | - 1 | EŞCRIBE HOW IN | JURY OCCURE | .D |
| 2 Accident Investigation | 28a PLACE OF IN HID | Y — At home, farm, stree | M 1 YES 2 NO | | | | |
| 3 Suicide 6 Could not be 4 Homicide determined | building, etc. (Spe | cify) | K, factory, office | | y or Town, State) | nd Number or Ru | ural Route Number, |
| 29e. CERTIFIER | | | | | | | |
| (Check only 1 CERTIFYING PHYSIC | JAN: To the best of my know | viedge, death occurred a | t the time, date end place, end | due to the co | euse(e) end mani | ner as stated. | |
| 2 MEDICAL EXAMINER | 3: On the basis of examination | on and/or investigation, is | n my opinion, death occured at | the time, dat | te end plece, end | due to the ceu | use(a) end menner se stated. |
| 29b. SIGNATURE AND TITLE OF SERTIFIER | Davi - | - 1 . N | 29c, LICENSE | NUMBER | I | 29d. DATE SIG | NED (Month, Day, Year) |
| Mulisa | Mexel | S MAD | MD-0 | 544- | 108 E | Dec | 6.1990 |
| 30. NAME AND ADDRESS OF PERSON WHO | | | | | | | - 2/1/ |
| MELISSA PETERS, | M.D. | KIMBROU | GH ARMY HOSP, | FT. | MEADE, | MD 20 | 755–5800 |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | S 3.274 | | | | | |
| 0 P 4000 | Li Krieban G | andell | | | | | |

BEC 0 1 1880



4.4

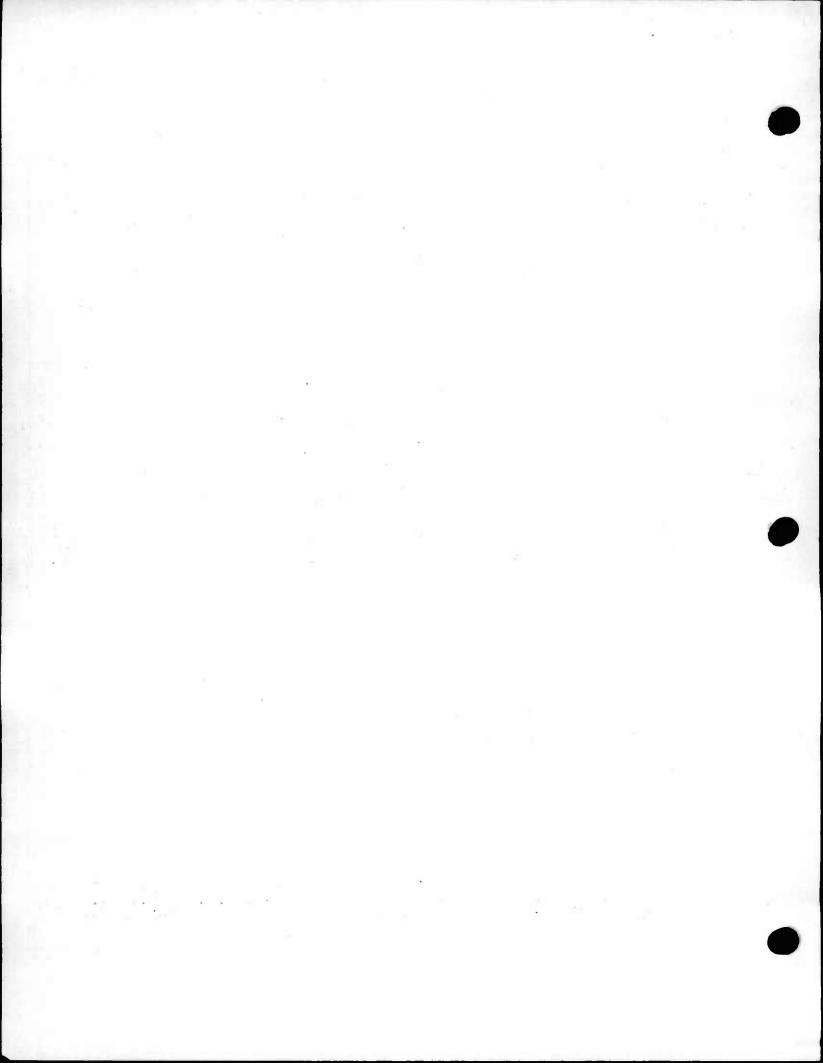
1 - FOR STATE REGISTRAR

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND I | MENTAL HYGIENE |
|--|----------------|
| CERTIFICATE OF DEATH | REG. NO. |

| | | 1. DECEDENT'S NAME (First, MARTHA | | E BOGGS | | | JOHN | ISON D | 2. DATE OF DECEMBE | ER 4,19 | 9 *6 48 | 5:02 AM M |
|--|---------------|--|--------------------------|--|----------------------------------|--|--------------------------------|--|---------------------------------------|--|-----------------------------|---|
| (1 |) | 4. SOCIAL SECURITY NUMB | BER | 5. SEX | 6. AGE (In yr | s. lest birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BI (Month, Day, DEC. | PTH (Year) 23,1920 | Country | PLACE (State or Foreign) NSYLVANIA |
| 3 should | _ | 9a. FACILITY NAME (If not in PHYSICIANS | stitution, give st | reet and number) | OSPIT | ΔТ. | | OR LOCATION OF D | | 9c. COU | ARLE | EATH |
| N | ē | RESIDENCE OF DEC | | /1(2114 11 | 00111 | A.u | HIL T | DILLIA. | | - 011 | ALL | |
| it. Pages 1, | DIRECTOR | 10a. STATE MARYLAND | CHAR | | | | , town or loc PLATA | CATION | | | | 10d. INSIDE CITY LIMITS? 1 TYES 2 K NO |
| регл | ¥ | 104. STREET AND NUMBER | | | | | | 101. ZIP CODE | | 10g. CIT | IZEN OF W | HAT COUNTRY? |
| ransit | FUNERAL | BOX # 391 / | ROUTE | | | | | 20646 | | | TED : | STATES |
| detached for use as the burial-transit permit. Pages once. | B⊀ | 11. MARITAL STATUS 1 Never Married 2 3 Never Married 2 Divo | | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE 1 | YES 2 | X NO | If yes, | ECENDENT OF HISPA specify Cuban, Mexic ES 2 X NO Specif | en, Puerto Rican | | 14. RACE Black Specif | — American Indian, , Whita, etc. fy: BLACK |
| 88 | | 15. DEC | EDENT'S EDUC | CATION completed) | 16 | | USUAL OCCUPA | | 16b. KINI | O OF BUSINESS/IN | DUSTRY | |
| for u | LET | Elementary/Secondary (0 | | College (1-4 or 5 | +) | life. Do NOT us | e retired.) | The state of the s | | | | |
| detached once. | COMPI | 9TH GRADE | | NONE | | DOMEST | IC | | | VATE | | |
| 8 % | BE CO | 17. FATHER'S NAME (First, M WILLIAM J. 1 | BOGGS | | | 1 | | ETHEL | COOMBS | | | , |
| page 5 should | 5 | 19a. INFORMANT'S NAME (7) MARGARET JOI | HNS | | | 82 US | 301s L | A PLATA, | | ND 2064 | 6 | |
| tor, pa | | 20a. METHOD OF DISPOSIT 1 ☐ Burlal 2 ☐ Crematic 4 ☐ Donetion 5 ☐ Other | n 3 🗆 Reme | oval from State | SAC | ACE OF DISPOS Der place) CRED HE | ART CHIL | remetery, cremetory or IRCH CEME? | rery | LA PLAT | | |
| Il direc | | 21. SIGNATURE OF FUNERA | | GHISEE I | | A III. | | AND ADDRESS OF FA | | LHI 12211 | , | |
| d in by the funeral director, for removal. | | LYDIA C | THOR | NTON JOH | NSON | insor | THOR | NTON'S FU | JNERAL | HOME, PO | MONK | EY, MARYLAND |
| completely filled in by the ial, cremation, or remove | | 23. PART I. Enter the d ahock, or h IMMEDIATE CAUSE (Fit disease or condition resulting in death) | eart failure. | s. Due for | | | least | Fally Line Chein Control Chein Control Chein Control Contr | ch aa cardlac | or reapiretory s | rrest, | Approximate Interval Between Onset and Death |
| en signed by the attending physician and completely filling of Health and Mental Hygiene prior to burial, cemation, thous any Inlury, or other traumatic event, the | CERTIFICATION | Sequentielly list condit if sny, leeding to imme cause. Enter UNDERLY CAUSE (Disease or Inju- thet Initiated events resulting in dasth) LAS | diate ING Iry | c. Due to | O (OR AS A CO | PINSEQUENCE OF | is a | hens nyonats | - | | | |
| ten signed by the at of Health and Ment | MEDICAL C | PART II. Other significa | ent condition | s contributing to | death but | not resulting | in the underly | ring cause given in | | WAS AN AUTOPSY PERFORMED? YES 2 X NO | 24b. | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| Dept. | AN | 25. WAS CASE REFERRED 1 | O MEDICAL | | | | 26 | PLACE OF DEATH (C | hack only one) | | | |
| rifficate has the State Dept or item 23 | SC | EXAMINER? | | HOSPITAL: | ☐ ER/Outpatie | ent 3 🗆 DOA | OTHER: | ome 5 - Residence | | ec(fv) | | |
| fter this certi eath with the | 표 | | Pending Investigation | 28a. DATE O | | 28b. TIM | E OF 28c. | INJURY AT WORK? | - | BE HOW INJURY O | CCUREO | |
| CTOR: After after deat | TED BY | 2 Accident 3 Suicide 6 4 Homicide | Could not be determined | 26e. PLACE building | OF INJURY — I, atc. (Specify) | At home, farm, | etreet, factory, of | ffica | | N (Street end Numb wn, State) | er or Rural f | Route Number, |
| THE FUNCETURE OF ALL LENDING PRINCIPLE. THE FUNCETURE LORGERORY After this certificate has be filled with the State Dept. PORTANT: If item 28 is marked, or item 23 is | 5 | Corrobon Gray | | | | | | late and place, and du | | | | i) and manner as etated. |
| TO THE FUNER TO THE WITHIN TO FILED WITHIN | 8 | 29b. SIGNATURE AND TITLE | w i | I fer | H | | | 29c. LICENSE NU D = 210 | | 29d. DA | 12/4 | (Month, Day, Year) |
| | 2 | 30. NAME AND ADDRESS O | F PERSON WH ANDREV | O COMPLETEO CAI V LEATH | ERWOO | D M D | PrintP O BOX | 249 WAL | DORF, | MARYLA | ND 2 | 20604 |
| | | 31. DATE FILED (Month, Day, DFC 0 4 | | 1 | Javidson | ure N-Randel | e | | | | | |

| FOR STATE | | PARTMENT OF HI | | ENTAL HYGIENE | | , 0,,00 |
|--|---|---|---|---|--------------------|--|
| REGISTRAR | CERI | IFICATE OF | JEAIR | REG. NO. | | 3. TIME OF DEATH |
| 1. DECEOENT'S NAME (First, Middle, Last) | Line | | | MONTH DAY | - 90 YEAR | 7:01 DH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 8. AGE (In yrs. last birth | day) IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. OATE OF BIRTH | 8. BIF | TTHPLACE (State or Foreign |
| 256 16 1/6/ | | RS. MONTHS DAYS | HOURS MIN. | (Month, Day, Year) Dec 26, 19 | 10 00 | untry) M |
| 9a. FACILITY NAME (If not institution, give sti | | 9b. CITY, TOWN OF | LOCATION OF OEA | | 9c. COUNTY OF | FOEATH |
| Deschorte | Co. Historia | Comb | ··do | 2 | Donal | her Te- |
| RESIDENCE OF DECEDENT | 3ex /4.19.101 | Camp | 7,09 | | 20.0 | |
| 10a. STATE 10b. COUNTY | 1 100 | C. CITY, TOWN OR LOCATI | NC | | | 10d. INSIDE CITY LIMITS? |
| Md. 100 | rcherle- | Lamba | idal | | | 1 YES 2 NO |
| 10e. STREET AND NUMBER | | 101. | ZIP CODE | | 10g. CITIZEN O | F WHAT COUNTRY? |
| RT2 BOX | 479-A | | 4613 | | U. | 5.A. |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVER IN U.S. ARMED- FORCES? 1 YES 2 NO | 13. WAS DECE | NDENT OF HISPANI city Cuban, Maxican | C ORIGIN? (Specify Yea , Puarto Rican, atc.) | В | ACE — American Indian, lack, White, etc. |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | 1 🗌 YES | 2 NO Specify: | | Sį | pocity: Black |
| 15. DECEDENT'S EDUC | CATION 160 DECEDI | ENT'S USUAL OCCUPATIO | N | 18b. KINO OF BUS | INESS/INDUSTR | 7- |
| (Specify only highest grade | completed) (Give kii | nd of work done during mos NOT use retired.) | t of working | | | |
| Elementary/Secondery (0-12) | College (1-4 or 5+) | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHER'S NAI | ME (First, Middle, Maiden | Surname) | |
| | 4. 11 | | Elia | aboth | Baile | V |
| 19a, INFORMANT'S NAME (Type/Print) | 19b. M/ | AILING ADDRESS (Street a | nd Number or Rural F | loute Number, City or Town | n, State, Zip Code | |
| Andrea Pi | do- B. | T)_ Bax | 479-A | Camboni | 1581 | Md. 216/3 |
| 20a, METHOO OF DISPOSITION | 20b. PLACE OF (| DISPOSITION (Name of cen | netery, cramatory or | 20c, LO | CATION - City o | or Town, State |
| 1 Burlal 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from Stata other plage) | irex (e | ne | C | mb ni | idas Md. |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | O AOORESS OF FA | CILITY | | 5// |
| Janell | Le C Henry R. | 6 6 | E | 1/4 | (. | L. MI |
| | compilcations that caused the death. | 7 11 | a VI UI | rerailed or respi | retory erreat | Approximete |
| 23. PART i. Setter the diseases, or shock, or heart fallure. | complications that caused the death. List only one cause on each line. | . Do not enter the mo | ae ot dying, suci | 1 es cardiac or respi | atory erreet, | intervai Between |
| IMMEDIATE CAUSE (Final | A CHARLES AND A COLUMN | | 2 | | | Onset and Death |
| disease or condition resulting in death) | a. METASTATIC Me bas bes i onserum | HYROID | ARCINE | MA | | 4-YR |
| | MG DOED DONE TOOMSEDIE | rgrold Cal | cinoma | | | 4 yr. |
| Sequentially liet conditions, | b | NOT OF | | | | |
| if eny, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUE | NCE OF J: | | | | |
| CAUSE (Disease or injury | CDUE TO (OR AS A CONSEQUE | NCE OFI: | | | | |
| that initiated events resulting in death) LAST | 002 10 (0.17)0 11 031102001 | | | | | |
| S-37/2 N | d | | | | | |
| PART ii. Other significant condition | ne contributing to death but not resu | uiting in the underlyin | g cause given in | Part i. 24a. WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | | | | 1 YES : | NO | COMPLETION OF CAUSE OF OEATH? |
| | | | | | | 1 TES 2 NO |
| | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | | 26. P | ACE OF DEATH (C) | eck only one) | | |
| 1 YES 2 NO | HOSPITAL: 1 Inpatient 2 PER/Outpatient 3 I | OTHER: DOA 4 Nursing Hor | ne 8 🗆 Residence | 8 Other (Specify) | | |
| 27. MANNER OF OEATH | | 8b. TIME OF 28c. IN | IURY AT | 28d. OESCRIBE HOW | INJURY OCCURE | ED |
| 1 Natural 5 Pending | (Month, Day, Year) | | YES 2 NO | | | |
| 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJURY At home. | , farm, street, factory, offi | 00 | 261. LOCATION (Street | | iural Route Number, |
| 3 Suicide 6 Could not be 4 Homicide determined | building, atc. (Specify) | | | City or Town, State | 7 | |
| 29a. CERTIFIER 1 FEBRUARY BUYE | SIC:AN: To the best of my knowledge, death | appropriate at the time date | and place and du | to the cause(s) and m | nner as stated | |
| (Check only | IER: On the basis of exemination and/or inv | | | | | ruse(a) and manner as stated. |
| | | ganton, many opinion, | | | | |
| 29b. SICHATURE AND TITLE OF CERTIFI | 5 | | 29c. LICENSE NU | MBER | 29d. DATE SI | GNEO (Month, Day, Year) |
| Liaia Mal | devere M | W | 2556 | fele | 110 | 21-90 |
| 30. NAME AND ADDRESS OF PERSON W | HO COMPLETED SAUGE OF DEATH (ITEM | D're Dorche | ster G | en. Hos. | Camb. | , Md. 21613 |
| CRAIG W. CALL | WELL LORCHE | STER GEL | 1./1050 | mr, CHM | BRICE | E MID |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE Sulia Davidson- | Rando De | | , | | |
| INTIV / Y 'Q | Summer of more | 1 | | | | |

DHMH-16 Rev 1/89



| | 1 - FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | 34406 |
|-------------------------|--|---|
| | | LAND |
| LETED BY FUNERAL DIRECT | MARYLAND ANNE ARUNDEL ANNAPOLIS 10e. STREET AND NUMBER 2 0 4 4 GATE DRIVE 11. MARITAL STATUS 1 Naver Married 2XXMarried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1XXYES 2 NO IF YES, GIVE WARP OR DATES KOREAN 15. DECEDENT'S EDUCATION (Give kind of working like, Do NOT loss retired.) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of working like, Do NOT loss retired.) 16b. KIND OF BUSINESS/INDUSTRY U. S. NAVAL ACADES | rican Indian, atc. |
| TO BE COMPLETED | PUBLIC WORKS DEP' 17. FATHER'S NAME (First, Middle, Lest) FREDERICK JOHNSON 18. MOTHER'S NAME (First, Middle, Meiden Surmerne) MARTHA HARROD 198. INFORMANT'S NAME (Type/Print) CLEMENTINE JOHNSON 2044 GATE DRIVE ANNAPOLIS, MD. 21401 | L |
| | 20c. METHOD OF DISPOSITION Comparison C | D. |
| | shock, or heart fallure. Liat only one cause on each line. | pproximate hterval Between maet and Death |
| CERTIFICATION | Sequentially list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DIA DETCS + NEP NTO PA / NY PO NO NO NO NEGLETICA OF NO NEGLETICA OF NO NEGLETICA OF NO NEGLETICA OF NEW NO NEGLETICA OF NEW NO NEGLETICA OF NEW NO NEW NEW NEW NEW NEW NEW NEW NEW NEW NEW | |
| MEDICAL | 1. Congestive Heart Failure 1 Tes 2 DNO OF DE | AUTOPSY FINDINGS BLE PRIOR TO ETION OF CAUSE ITH? ES 2 NO |
| TED BY PHYSICIAN: | EXAMINER? 1 YES 2 NO 1 Inpatiant 2 EN/Outpetient 3 DOA 4 Nursing Hore 5 Realdance 6 Other (Specify) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Sulcide 8 Could not be determined 2 Accident 3 Sulcide 8 Could not be determined | mber, |
| TO BE COMPLETED | 29a. CERTIFIER (Check only One) 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, In My Opinion) 29d. DATE SIGNED (Month, In My Opinion) 29d. DATE SIGNED (Month, In My Opinion) 29d. DATE SIGNED (Month, In My Opinion) | |

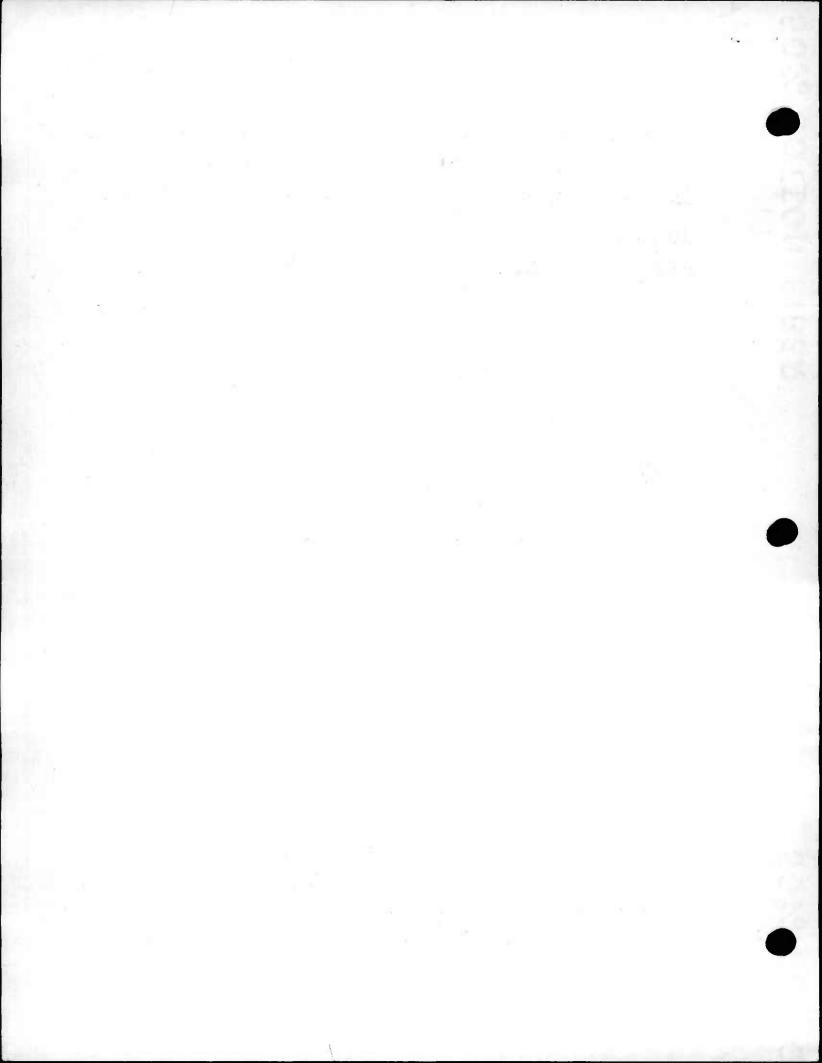
PLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

FY (W)

205 Roose,

| is after death. Page 6 may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-transit permit. Page removal. dical examiner must be notified at once. | TO BE COMPLETED BY FUNERAL DIREC |
|--|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any month of the death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, certainly, or removal. IMPORTANT: If I have 28 is marked, or item 23 shows any Injury, or other traumatte event, the medical examiner must be notified at once. | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |

| 1 - FOR STATE REGISTRAR | STATE OF MARYL | | NT OF HEALTH AND TE OF DEATH | MENTAL HYGIEN REG. NO | | |
|---|--|--|---|---|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | Roy Clifton | | | 2, DATE OF OEATH | AYON 90EA | 3. TIME OF DEATH 3: 10PM |
| 4. SOCIAL SECURITY NUMBER | | | IDER 1 YEAR IF UNDER 24 HRS HS DAYS HOURS MIN. | 7. DATE OF BIRTN (Month, Day, Year) | Co | RTHPLACE (State or Foreign unity) |
| 9a, FACILITY NAME (If not igstitution, give | street and number) ty Gen Ho | spital 1 | Destminste | | Cari | |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUN | roll | 10c. CITY, TOU | WN OR LOCATION Bridge | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| 10e. STREET AND NUMBER | * | 10.71.07 | 101, ZIP/CODE | , | | OF WHAT COUNTRY? |
| 10 9 Lightner 5 11. MARITAL STATUS 1 Never Married 2 A Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 X YES IF YES, GIVE WAR OR I | 2 NO | 13. WAS DECENDENT OF NIS If yes, specify Cuban, Mes 1 YES 2 X NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific NO Specific N | PANIC ORIGIN? (Specify Yelican, Puarto Rican, atc.) | E | A. ACE — American Indian, Black, White, etc. White |
| 15. DECEDENT'S ED (Specify only highest grad Elementary/Secondary (0-12) | UCATION | ine. Do NOI use retii | one during most of working | | line | |
| 11 17. FATHER'S NAME (First, Middle, Last) | | THACLUI L | | NAME (First, Middle, Maide | | |
| Roy C. Joi | hnson, Sr. | | | rah Bostia | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 27 27 20 27 34 34 34 34 | RESS (Street and Number or Runter St. UI | | | |
| Shirley A. Johnson 100 Method of Disposition 100 Burlel 2 Cremetton 3 - Re | | b. PLACE OF DISPOSITIO | N (Name of cemetery, crematory | | OCATION — City | |
| 1 🖾 Burial 2 🗆 Cremation 3 🗀 Ra 4 🗆 Donation 5 🗀 Other (Specify) | movat from Stata | Mt. Vie | w Cemetery | Un | ion Bri | dge, MD |
| 21. SIGNATURE OF FUNERAL SERVICE I | O. Hart | ler | 22. NAME AND ADDRESS OF Union Bri | D. D. H | lartzler | m & Sons |
| Sequentielly list conditions, if amy, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events | b. OUE TO (OR AS | A CONSEQUENCE OF): A CONSEQUENCE OF): | ung Cai | ce | | |
| PART II. Other significant condition | one contributing to death | but not resulting in the | e underlying ceuse giver | in Part I. 24a. WAS A PERFO | AN AUTOPSY DRMED? 2 \(\square\) NO | 24b. WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | O | 26. PLACE OF DEATH | (Check only one) | | |
| 1 YES 2 NO 27. MANNER OF DEATN | 1 Inpetient 2 ER/Or 28e. DATE OF INJUR (Month, Day, Year | ritpatient 3 DOA 4 | Nursing Nome 5 🗌 Reside | 28d. DESCRIBE HOV | V INJURY OCCUR | ED |
| 1 Natural 5 Pending | | | | | | |
| 1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not I 4 Nomicide determined | 28e. PLACE OF INJU building, atc. (S | RY — Al home, farm, stree | | 28f. LOCATION (Stree City or Town, Sta | et and Number or F te) | lural Route Number, |
| 2 Accident Investigatio 3 Suicide 6 Could not I 4 Nomicide determined 29e. CERTIFIER (Check only | 28e. PLACE OF INJU building, atc. (S | owledge, death occurred a | t, factory, office | City or Town, Sta | nanner as stated. | |
| 2 Accident Investigation 3 Suicide 6 Could not I 4 Nomicide determined 29e. CERTIFIER 1 CERTIFYING PH | 28e. PLACE OF INJU- building, stc. (S) YSICIAN: To the best of my kn- INER: On the basis of examina | owledge, death occurred ston and/or investigation, in | t, factory, office the time, data and place, and my opinion, death occured a 29c. LICENSE | City or Town, Sta dua to the cause(a) and n the time, data and place, | nanner as stated. | |



1 - FOR STATE REGISTRAR

| | | HEGIOTITIAT | | | | | | | Committee of the Commit |
|--|---------------|--|--|-----------------------|-------------------------|------------------------------------|--|---------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | TO | NSON | | | 2. DATE OF DEATH | Y 9 YEAR | 3. TIME OF DEATH |
| | | 4. SOCIAL SECURITY NUMBER 5. | | n yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | - V | THPLACE (State or Foreign |
| |] | 4 4 4 | | 93 YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) 4 - 22 - | Cou | VA |
| pino | 1 | 9s. FACILITY NAME (If not institution, give street | | / | 9b. CITY, TOWN C | OR LOCATION OF DE | | 9c. COUNTY OF | DEATH |
| - Offi | Œ | HOWARD COUNT | y Gen. H | ospital | | embla | | Howa | RRD |
| the d | 5 | RESIDENCE OF DECEDENT | 7 | | | | | | |
| | DIRECTOR | 10e. STATE 10b. COUNTY | IAPD | | Y, TOWN OR LOCAT | | | | 10d. INSIDE CITY LIMITS? |
| | | | IARD | | OLUML | | | L 40- CITIZEN O | 1 TYES 2 NO |
| реглії | FUNERAL | 10e. STREET AND NUMBER | 0.00 | | 101 | 21044 | Ĺ | U. 5 | |
| physician. buriaf-transft | W W | 10353 ROSLUN 11. MARITAL STATUS | . WAS DECEDENT EVER IN | IIIS ADMEO | 13 WAS DEC | 01011 | NIC ORIGIN? (Specify Yes | or No- 14, R/ | ACE - American Indian, |
| physician. burial-tran | | 1 Never Merried 2 Merried | FORCES? 1 YES | 2 NO | If yes, sp | ecify Cubsn, Mexico 2 NO Specif | n, Puerto Ricen, etc.) | Bi Sa | leck, Whits, stc. pecify: |
| | BY | 3 Wildowed 4 Divorced | ir ies, dive wan on o | | | - 4 | , | | BLACK |
| r attending use as the | ETED | 15. OECEDENT'S EDUCAT (Specify only highest grade con | ION np(eted) | (Give kind of | work done during me | ON ost of working | 16b. KIND OF BU | SINESS/INDUSTR | Y |
| P 5 | 191 | | College (1-4 or 5+) | life. Do NOT L | | EDER | | | |
| the hospital detached fo | COMPL | | | 17043 | SEKEL | | and agree a straight the later | S | |
| the hos detach | 8 | 17. FATHER'S NAME (First, Middle, Lest) | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | | HACALD |
| T A A A A | | The state of the s | | 10h MAII IM | C ADDRESS (Street | and Number or Burel | Route Number, City or Tow | | UMGOLD |
| retained 5 should notified | ٩ | 190. INFORMANT'S NAME (Type/Print) LARRY SMIT! | 7 | | | | DR. RAN | | |
| _ 20 8 e | | | | | SITION (Name of ce | | 20c. LC | OCATION — City o | r Town, Stats |
| 6 m ctor, | | 20s_METHOD OF DISPOSITION 1 | I from State | other placa) | 0415 | | CL | ARKS | ILLE MD. |
| الم الم | | 21. SIGNATURE OF FUNERAL SERVICE LICEN | ISEE C | | 22. NAME A | NO ADDRESS OF F | ACILITY | | |
| death. P death. P funeral | | + Harry H | 11/1/1/16 | | 4/10 | LEOLUM | BIA PK | 10 2101 | 1.2 |
| L 2 12 | | 23. PART I. Entar tha discussea, or cor | nolications that cause | d the death. Do | not antar the me | oda of dying, au | ch as cardiac or resp | olratory arrest, | Approximata |
| ours afte 1 in by th or remov | | ahock, or hear failure. Lis | at only one cadee on a | ach lina. | | | | | Interval Batwaan Onset and Death |
| y filled trion, | | IMMEDIATE CAUSE (Final disease or condition | Sepons |) | | | | | |
| d within ompletel i, crema | | resulting in death) a | DUE TO (OR AS | A CONSEQUENCE | OF): | | | | |
| 4 8 2 4 | | b. | Decul | Mi | | | | | |
| 1 00 E | CERTIFICATION | Sequentially list conditions, if any, leading to immediate | OUE TO (OR AS | A CONSEQUENCE | Ma D And | farction | | | |
| | 5 | CAUSE (Disease or injury | | CONSEQUENCE | | 10000-01 | | | <u> </u> |
| certificat ding phy tygiene p | | that initiated avents resulting in death) LAST | Litema | ALIMA | <u>~</u> | | | | |
| - E E E | | d. |) pe | 000 (0) 0 | | | | | |
| the d Mee | 5 | PART II. Other significant conditions | | but not reaulting | in the underlying | ng causa givan i | n Part I. 24a. WAS A | N AUTOPSY DRMED? | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| RECORDS requires that the seen signed by the of Health and M | MEDICAL | | Smar | 2000 | marine | U h AMA O | O S A S A S A S A S A S A S A S A S A S | 2 NO | COMPLETION OF CAUSE OF DEATH? |
| () = 8 P | WE | | alia | Lange Co. | 14 (M) (M) 4 | a I DIVO | The state of the s | 1 | 1 YES 2 NO |
| AL RE | Z | | | | | | | | |
| F 2 2 2 2 | HYSICIAN: | | HOSPITAL: | THE . P. S. | OTHER: | PLACE OF OEATH (C | | | |
| SICIAN: The certificate h the State l | S × | 1 YES 2 NO | 1 Inpatient 2 ER/Out 28s. DATE OF INJURY | | | oms 5 ☐ Residence | 6 Other (Specify) 26d. OESCRIBE HOW | V INJURY OCCURE | E0 |
| O F in it | <u> </u> | Natural 5 Pending | (Month, Day, Year) | | NJURY V | VORK? YES 2 NO | | | |
| | | 2 Accident Investigation 3 Suicide 6 Could not be | 28e. PLACE OF INJUR | Y — At homs, farm | n, street, factory, off | fice | 26f. LOCATION (Street | at and Number or R | tural Route Number, |
| DIVISION DR ATTENDING DIRECTOR: After hours after death | | 4 Homicide 6 Could not be | building, etc. (Spi | ecity) | | | City or Town, Stat | (0) | |
| DIVISION DR ATTENDING DIRECTOR: After hours after death | | 298. CERTIFIER CERTIFYING PHYSICI | IAN: To the best of my kno | wledge, death occ | urred at the time, da | its and place, and d | ue to the ceuse(s) end m | snner ee stated. | |
| 4 4 K : | = = | (Check only | | | | | | | ouse(s) and menner as stated. |
| HOSPITAL FUNERAL within 72 h | S | 29b, BIGHATURE AND TURE OF CERTIFIETY | 7/1/ | nA.O | | 29c. LICENSE N | | 29d. DATE SIG | CNED (MGren) DE Year) |
| | O BE CO | Acatt 1116 | mu on 1 | VY | | 1129 | 909 | ► U// | 20/10 |
| 553 | 일 | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF | DEATH (ITEM 27) (7) | rpe, Print) | 1.100. | 1000 | | 1.0. |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

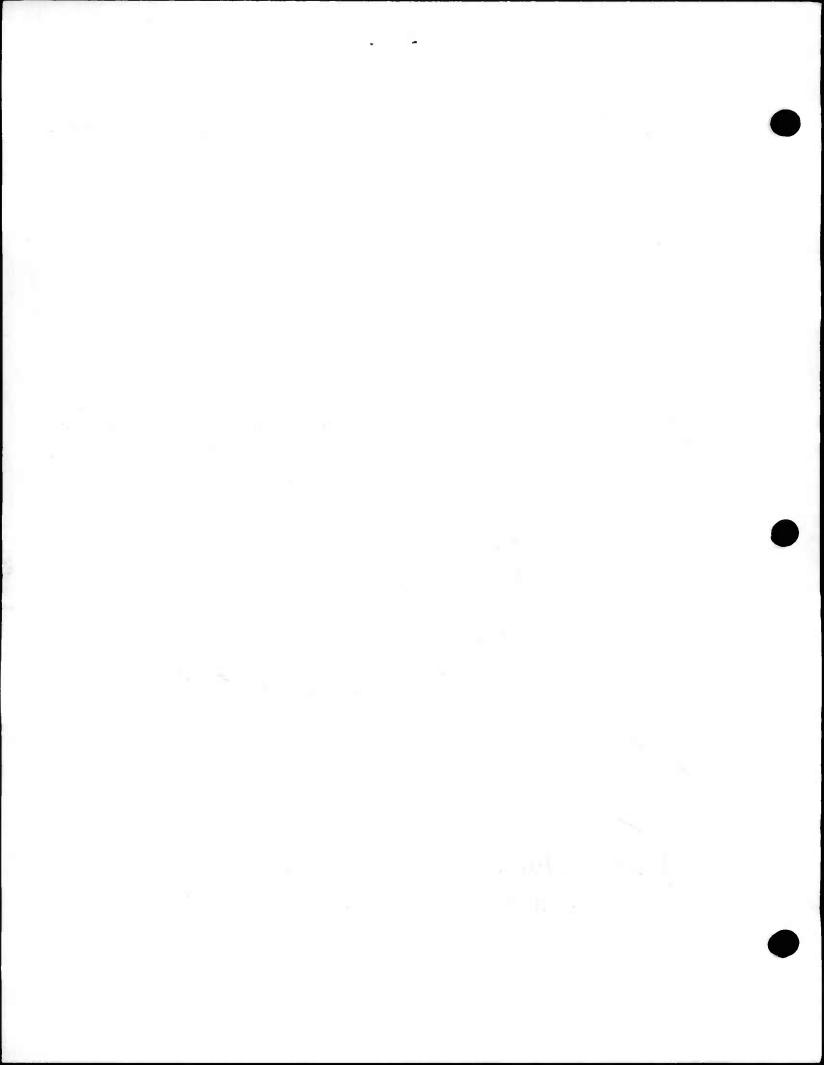
SCUTT MALKER MP 9501 DLO ANNAPOLIS RO

32. REGISTRAR'S SIGNATURE

31. DATE FILEO (Month, Day, Year)
NOV 29 190

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

TELLICOT CIT

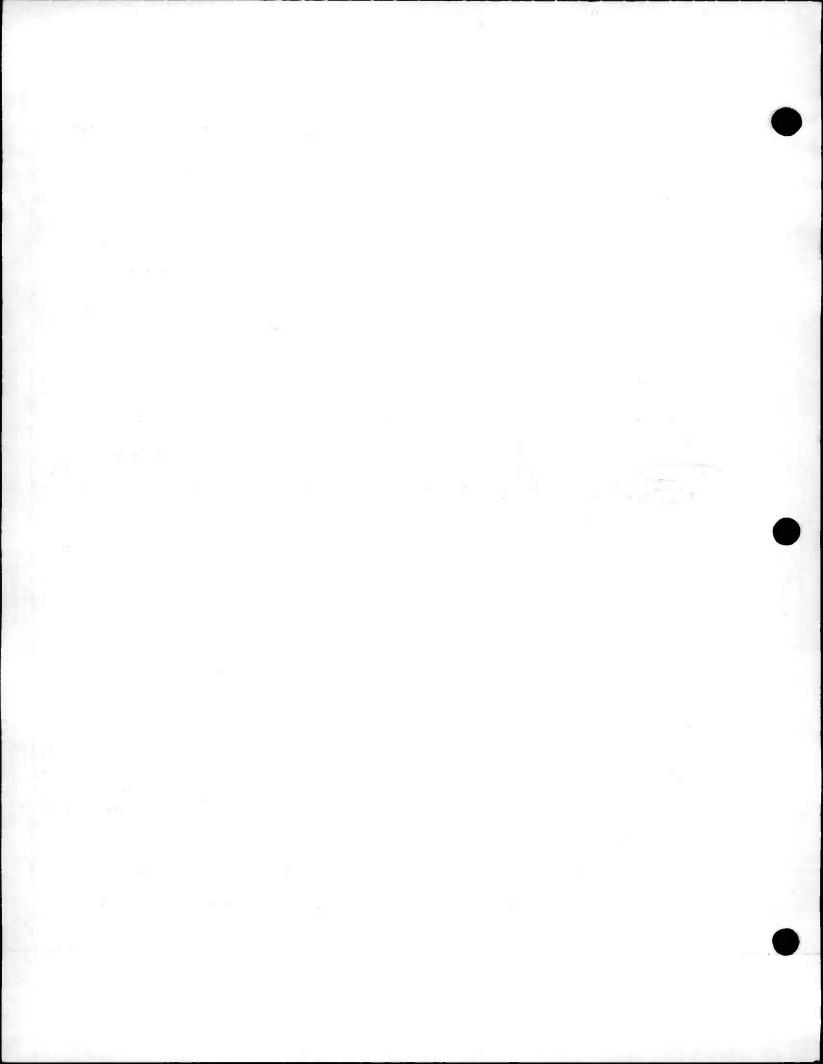


| DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146 | |
|---|----|
| portal, OA ATTENDING PAYSICIAN. The law requires that the death certificate be escused whom to, looking and completely filled in by the funeral director, page 5 should be detached for use as the burish-basers permit. Pages 1, 2, 3 should | 70 |

| | 1. DECEDENT'S NAME (First, MIRRI, Last) | | | | CATE OF | | | E OF DEA | I. NO. | YEAR | 3. TIME OF DEATH |
|--|--|--|--|--|---|--|-----------|--|---|--|--|
| 1 | JAMES | RICH/ | RD | | JOYNER | JR. | мон | 11 | 25 | 90 | 4:00 A |
| -1 | 4. SOCIAL SECURITY NUMBER | S. SEX | 6. AGE (In yes. I | | F UNDER 1 YEAR | IF UNDER 24 MISS. | | E OF BIRT | | B. BIFF | THPLACE /State or Foreign |
| 1 | 214-72-3370 | 1 (<u>C</u> M 2 □ F | 32 | 2 YRS. | MONTHS DAYS | HOURS MIN. | | | 2,1957 | 7,553.11 | uth Carolina |
| | So. FACILITY NAME (If not institution, give | atreet and number) | | | Sb. CITY, TOWN | OR LOCATION OF E | HTASE | | 9c. (| COUNTY OF | DEATH |
| DINECTOR | Old Indian Head | d Road | | | | | | | | Cha | rles |
| 5 | RESIDENCE OF DECEDENT | ry | | toe City | TOWN OR LOCA | KTION | | | | | 10d. INSIDE CITY |
| Ĭ | Maryland Charl | a constr | | LaP1 | | | | | | | 1 TES 2 NO |
| | 100. STREET AND NUMBER | res | | Lari | | or, ZIP CODE | | | 10g. | CITIZEN O | F WHAT COUNTRY? |
| | 608 Worchester St | Face . | | | | 20646 | | | | J.S.A | |
| LONERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | EVER IN U.S. | ARMED | | CENDENT OF HISPA | | | city Yes or No | - 14, RJ | ACE - American Indian, lack, White, etc. |
| 10 | 1 Never Married 2 Married | FORCES? 1 IF YES, GIVE W | AR OR DATES | IMO | | pecify Cuben, Mexic S 2 RO Spec | | o rocan, s | etic.) | 10.55 | secify: |
| | 3 Widowed 4 X Diverced | 11976 - 1 | K-K | | 1 | | | | | | white |
| | 18. DECEDENT'S ED (Specify only highest grad | ME completed) | | | ISUAL OCCUPAT ork done during in | | 1 | 66. KIND | OF BUSINESS | S/INDUSTR | |
| 9 | Elementary/Secondary (0-t2) 12 | College (1-4 or 5 + |) | aborer | SCHOOL STATE | | | Cone | truct | ion | |
| 2 | 17. FATHER'S NAME (First, Microlin, Lant) | | | abor er | | 18. MOTHER'S N | _ | | | | |
| | James Richard | Joyner | Sr. | | | I service construction | | ****** | tepher | | |
| 20 | 19a. INFORMANT'S HAME (Type/Prox) | o o j no i | | 10b. MAILING | ADDRESS (Street | and Number or Run | _ | | | | |
| 2 | James R. Joyner S | Sr. | | 4807 N | . Barn | aby Lane | Tem | ple | Hills | MD. | 20748 |
| | 20s. METHOD OF DISPOSITION | - | 20b. PLAC | CE OF DISPOS | | wnotery, cremetory or | | - | 20s. LOCATIO | | Yown, State |
| | 1 1 Burtat 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify) | movel from Santa | | obel - | Kelfor | d Cemete | erv | 1 | Roxobe | 1. N. | . C. |
| _ | OH SHOMATURE OF FUNERAL SERVICE L | LICENSEE | *************************************** | | 22. NAME | AND ADDRESS OF | FACILITY | | 4. | 308 5 | uitland Rd. |
| | 1 1 | 11 4 | | | | | | | 194 | | |
| | 23. PART I. Enter the diseases, or shock, or heart sellure IMMEDIATE CAUSE (Final) | | | | | | | | nc. S | uitla | nd, MD. 207 |
| NO | shock, or heart sollare IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | a. List only one cer. a. Multiploue to | se on each li | ITIOS SEQUENCE OF | ot enter the m | | | | nc. S | uitla | nd, MD. 207 |
| CATION | shock, or heart sillure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING | a. List only one cer. a. Multiploue to | e on each N | ITIOS SEQUENCE OF | ot enter the m | | | | nc. S | uitla | nd, MD. 207 |
| IFICATION | shock, or heart sollare IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Multiploue To | e on each N | IT 1 0 S SEQUENCE OF | ot enter the m | | | | nc. S | uitla | nd, MD. 207 |
| EHTIFICATION | shock, or heart sollare IMMEDIATE CAUSE (Final- disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | a. Multiploue To | Le inju | IT 1 0 S SEQUENCE OF | ot enter the m | | | | nc. S | uitla | nd, MD. 207 |
| AL CERTIFI | shock, or heart sollare IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. Multiploue To b. OUE TO c. OUE TO | OR AS A CON | IT 10.5 SEQUENCE OF | ot enter the m | node of dying, su | uch as c | ardiec o | nc. S | uitla y arrest, | nd, MD. 207 |
| MEDICAL CERTIF | shock, or heart sellure IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significant conditions | a. Multiploue To b. OUE TO c. OUE TO | OR AS A CON | IT 10.5 SEQUENCE OF | ot enter the m | node of dying, so | in Part I | ardisc of | nc. Si | uitla y arrest, | Approximate interval Betwee Onset and Dec Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Onset and Dec Dec Dec Onset and Dec Dec Dec Dec Dec Dec Dec Dec Dec Dec |
| MEDICAL CERTIF | shock, or heart sollare IMMEDIATE CAUSE (Finish disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | a. Multipoue to a. Multipoue to b. OUE TO c. OUE TO d. One contributing to | OR AS A CON | IT 10.5 SEQUENCE OF SEQUENCE OF SEQUENCE OF | ot enter the m 2: 7: 7: 7: 7: OTHER: | ing cause given | in Part I | andlet of | TIC . SI | uitla y arrest, | Approximate interval Betwee Onset and Del On |
| SICIAN: MEDICAL CERTIFI | shock, or heart sollure IMMEDIATE CAUSE (Finish disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions 25. WAS CASE REFERRED TO MEDICAL EXAMINERY 1 X YES 2 MO | a. Multip. a. Multip. oue To b. oue To c. oue To d. ons contributing to | OR AS A CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONSIDER OF THE CONS | TIOS SEQUENCE OF SEQUENCE OF SEQUENCE OF | ot enter the m | ing cause given | in Part I | andlet of | TIC . SI | y arrest, | Approximate interval Betwee Onset and Del On |
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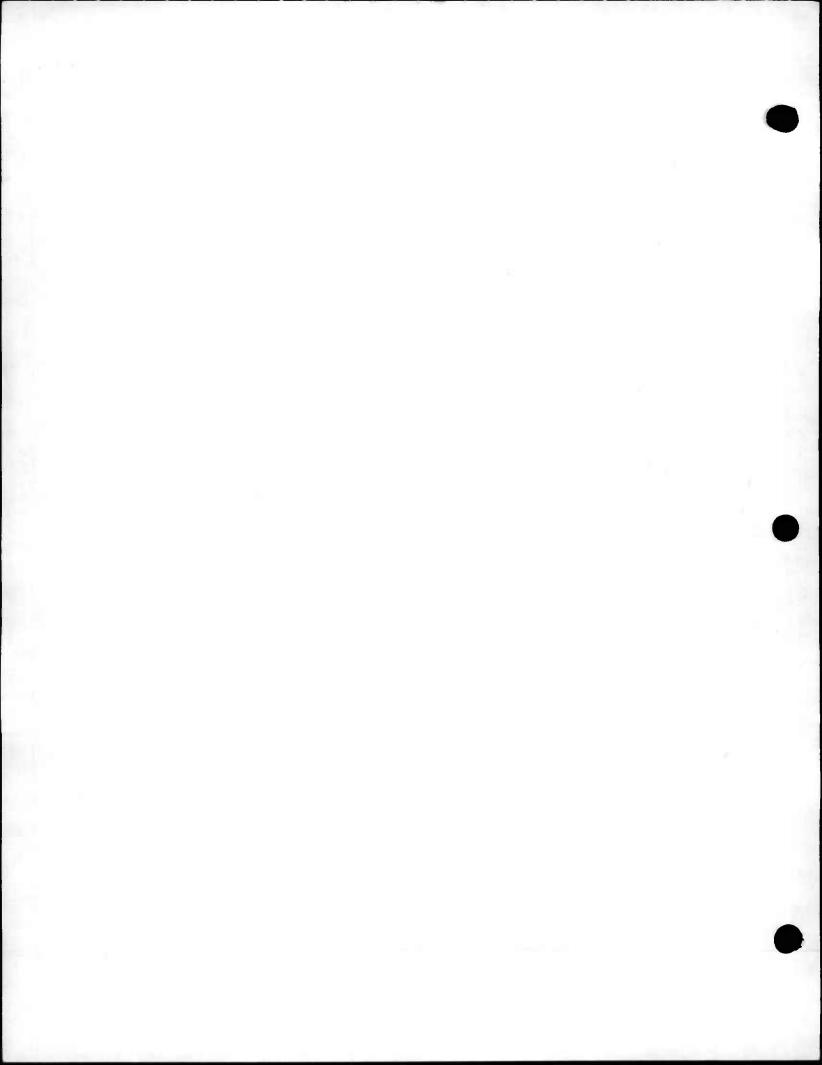
1 VA

DHMH-16 Rev 1/80



TO BE COMPLETED BY FUNERAL DIRECTOR

| REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | CERTIFICATE | OF DEATH | REG. NO. | | |
|--|--|--|--|--|--|
| 10000 | | | 2. DATE OF DEATH DAY 11-20-90 | | 3. TIME OF DEATH 9:53PM M |
| A. SOCIAL SECURITY NUMBER 5. SEX 6. | JONES AGE (in yrs. last birthday) IF UNDER 1 | | 7. DATE OF BIRTH | 8. BIR | RTHPLACE (State or Foreign |
| 1 July 2 F | | DAYS HOURS MIN. | (Month, Day, Year) Oct. 17,1 | .966 Wa | ashington, DC |
| 9e. FACILITY NAME (If not institution, give street and number) | 24 | TOWN OR LOCATION OF DEA | | 9c. COUNTY OF | |
| Andrews Air Force Base Ho | spital (| Camp Springs | | Prince | Georges Co. |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | 10c. CITY, TOWN OF | | | | 10d. INSIDE CITY LIMITS? |
| D.C. N/A | Washir | ngton | | | 1X YES 2 NO |
| 10e. STREET AND NUMBER | F 1971 2 31971 | 101. ZIP COOE | 1 | | OF WHAT COUNTRY? |
| 606 Kensington Place N.E. | | 2001 | | USA | ACE - American Indian, |
| 11. MARITAL STATUS 12. WAS DECEDENT FORCES? 1 | YES 2 V NO II | WAS DECENDENT OF HISPAN If yes, specify Cuben, Mexican | , Puerto Rican, etc.) | В | Black, White, etc. Specify: |
| 1 Never Merried 2 Merried IF YES, GIVE WAI 3 Widowed 4 Divorced | H OR DATES 1 | YES 2 NO Specify | | | Black |
| 15. OECEDENT'S EDUCATION | 18a. DECEDENT'S USUAL OC (Give kind of work done of | CCUPATION furing most of working | 18b. KIND OF BU | SINESS/INDUSTR | |
| (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5+) | life. Do NOT use retired.) | | Mini F | ress | |
| 12th | Printer | 10 MANAGEMENT | ME (First, Middle, Meiden | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | / | |
| Melvin G. Fleming 190. INFORMANT'S NAME (Type/Print) | 19b. MAILING ADDRESS | S (Street and Number or Rural F | V Jones Route Number, City or Tow | m, State, Zip Code | 9) |
| Beverly Fleming | | ngton Pl. NW | | | |
| AND METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITION (Na | ame of cemetery, crematory or | 20c. LC | CATION — City of | or Town, State |
| 1 Buriel 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) | Harmony Me | emorial Park | | andover | , Md. |
| 21. SIGNATURE OF FUNERAL BERVICE LICENSEE Report A Complete Compl | el M | name and address of fa Marshall's Fu +217 9th St N | meral Hom | oton. D | C 20011 |
| Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING | le gunshot wound (OR AS A CONSEQUENCE OF): (OR AS A CONSEQUENCE OF): | | | | |
| CAUSE (Diseese or injury | | | | | |
| OALLOS (Diseases or initial) | | | | | |
| CAUSE (Disease or injury that initiated events | death but not resulting in the u | inderlying cause given in | | NAUTOPSY ORMED? 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 \(\sqrt{N} \) NO |
| CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to | death but not resulting in the u | anderlying cause given in | PERFE | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| CAUSE (Disease or injury that initiated events reaulting in death) LAST PART II. Other aignificant conditions contributing to 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: | ОТНЕ | 28. PLACE OF DEATH (C | PERFO | ORMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| DUE TO that initiated events resulting in death) LAST PART II. Other significant conditions contributing to 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXES 2 NO 1 Inpatient 2X 27. MANNER OF DEATH 1 Netural 5 Pending 1.1—26. | | 28. PLACE OF DEATH (CER: unring Home 5 - Residence | PERFO | ORMED? 2 NO | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XX YES 2 \(\subseteq NO |
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| CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXES 2 NO 1 Inputer 2X 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident Investigation 3 Suicide a Could not be determined 28e. PLACE Of building, | OF INJURY 28b. TIME OF 8 3 DDA OF INJURY 28b. TIME OF 8 3 DDA OF INJURY — At home, farm, street, fa , etc. (Specify) Street of my knowledge, death occurred at the | 28. PLACE OF DEATH (CER: ursing Home 5 Residence 28c. INJURY AT WORK? 1 YES NO actory, office | PERFORMANCE OF THE PROPERTY OF | ORMED? 2 NO WINJURY OCCUR The Shot et and Number or Time G menner as stated. | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MX YES 2 NO RED Rural Route Number, Ave., District |
| DUE TO that initiated events resulting in death) LAST PART II. Other aignificant conditions contributing to 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXES 2 NO 1 Impattent 2X 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 2 Accident 3 Suicide a Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of the could not be determined) | OF INJURY 28b. TIME OF 8 3 DDA OF INJURY 28b. TIME OF 8 3 DDA OF INJURY — At home, farm, street, fa , etc. (Specify) Street of my knowledge, death occurred at the | 28. PLACE OF DEATH (CER: 28c. INJURY AT WORK? 1 YES NO actory, office e time, dete and place, and dry opinion, death occurred at till 29c. LICENSE N | PERFORMANCE OF THE PERFORMANCE O | VINJURY OCCUR The Shot of end Number or rieglenn Three Genner as stated. end due to the call of th | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? MX YES 2 NO RED Rural Route Number, Ave., District |
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| DUE TO that initiated events reaulting in death) LAST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide Society Homicide a Could not be determined 29e. CERTIFIER Check only one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) 2XX MEDICAL EXAMINER: On the basis of could not be determined control one) | FINJURY 28b. TIME OF 8°. 3UPM FINJURY 28b. TIME OF 8°. 3UPM OF INJURY — At home, farm, street, farm, etc. (Specify) Street of my knowledge, death occurred at the examination and/or investigation, in my | 28. PLACE OF DEATH (CER: 28c. INJURY AT WORK? 1 YES NO actory, office e time, dete and place, and dry opinion, death occurred at till 29c. LICENSE N | Theck only one) a to Other (Specify) 28d. DESCRIBE HOVE SUDJECTORY 28t. LOCATION (Street 25-20 New TEIGHTS, P. us to the cause(e) and inchesting, date end place, umber UMBER | VINJURY OCCUR The Shot In the state of the | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NIX YES 2 NO RED RURAL Route Number, AVE., District Cause(e) and menner ee stated. SIGNED (Month, Dey, Year) 11-21-90 |

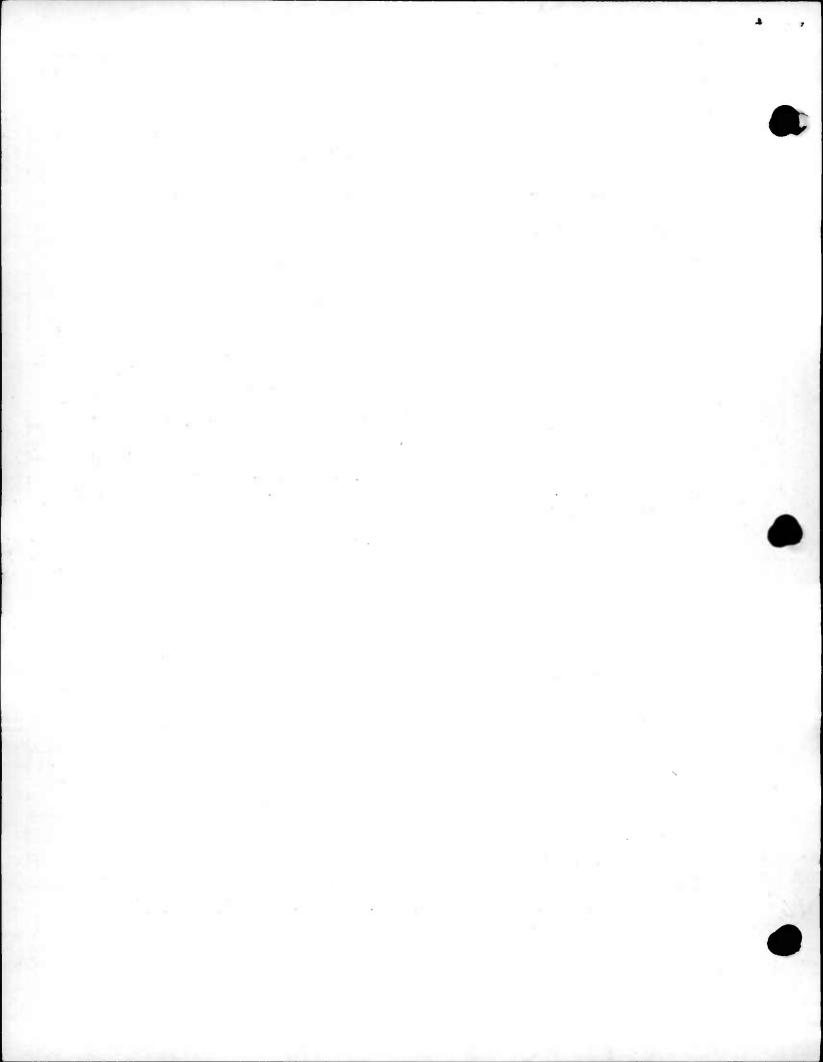


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| STATE OF MARYLAND / DEPARTMENT | OF HEALTH AND MENTAL | HYGIENE |
|--------------------------------|----------------------|----------|
| CERTIFICATE | E OF DEATH | REG. NO. |

| | | - REGISTRAR | STATE OF MARYLAI | | TMENT OF | | REG. NO. | _ | |
|--|---------------|--|---|---------------------------------|--------------------------------|---|--|---------------------|--|
| | | 1. DECEDENT'S NAME (First, Middle, Linst) Eugene | | asmund, | Jr. | | 2. DATE OF DEATH OF NOVEMber I | | |
| | | 212-54-2356 | X м 2 □ F 27 | yrs. last birthday) YRS. | IF UNDER 1 YEAR MONTHS DAYS | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 3-24-19 | 63 Was | hington, DC |
| F) | TOR | 9e. FACILITY NAME (If not institution, give stree 1404 Birchwood I RESIDENCE OF DECEDENT | * | | 96. CITY, TOWN | Hill | EATH | Prince (| George's |
| - No. | DIRECTOR | 10a. STATE 10b. COUNTY | e Georges | 10c. CIT | Oxon H | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| nsit permit | FUNERAL | 100. STREET AND NUMBER 1404 Birchwood Dri | ve | 1. | 1 | 01. ZIP COOE | 45 | 10g. CITIZEN OF | WHAT COUNTRY? USA |
| AND 21203-3146 the hospital or attending physician. detached for use as the burial-transit permit. | ВУ | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | P. WAS OECEOENT EVER IN 1 FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 XNO | If yea, s | | NIC ORIGIN? (Specity Yea an, Puarto Rican, atc.) fy: | | |
| 2120; ital or atte | PLETED | | | (Give kind of life. Do NOT u | | nost of working | | SINESS/INDUSTRY | |
| ₽ ₽ ₽ ₽ | BE COMPLET | 12th 17. FATHER'S NAME (First, Middle, Last) Eugene Rober | t Jasmund, S | | Entry (| 18. MOTHER'S NA | <u> Prince</u> AME (First, Middle, Malden Oyce Anne | Surname) | s Co. Police |
| 2 2 0 | TO B | 194. INFORMANT'S NAME (Type/Print) Joyce Anne Towne | r | 19b. MAILING | Birchwo | and Number or Rural ood Drive | Route Number, City or Tow | n, State, Zip Code) | |
| Page 6 mi I director, | | 20s. METHOO OF DISPOSITION 1 Buriel 2 X Cremetion 3 Remove 4 Donation 5 Other (Specify) 21. SIGNATURE OF THE REPORT OF THE REPORT OF THE REPORT OF THE REPORT OF THE REPORT OF THE REPORT OF THE REPORT OF THE REPORT OF T | | other place) | olitan C | emetery, crematory or Crematory AND ADDRESS OF FA | A1 | exandria | |
| BALTIM rs after death. Page or by the funeral dir removal. | | · West flats | | | 616 | 0 Oxon H | | on Hill, | Md. 20745 |
| thin car nouns thely filled in the mation, or re- | | 23. PART I. Enter the diseasee, or cor shock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition resulting in death) | | alus wi | th Seizu | | | eratory arrast, | Approximata Interval Between Onset and Deatl |
| .O. BOX 13: the certificate be executed physician and Hygiene prior to bur or other traumatic | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initisted events resulting in death) LAST | DUE TO (OR AS A O | | | | - | | |
| RECORD requires that been signed by of Health and shows any | : MEDICAL | PART II. Other significant conditions Spina Bifida | contributing to death bu | t not resulting | in the underly | ng cause given in | Part I. 24e. WAS AN PERFO | RMED? | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 NO |
| The lar | PHYSICIAN | | tOSPITAL: | tlent 3 DOA | OTHER: | PLACE OF DEATH (C) | | | |
| | ву РНУ | 27. MANNER OF OEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TII | ME OF 28c. II | NJURY AT VORK? YES 2 NO | 28d. DESCRIBE HOW | INJURY OCCURED | |
| ISIO TTENDI TTOR: A after da | | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY - building, etc. (Specif | At home, ferm, | atreet, factory, of | fice | 281. LOCATION (Street City or Town, State | | al Route Number, |
| E 46 = | COMPLETED | one) 2 MEDICAL EXAMINER: | N: To the best of my knowle On the besis of examination | | | | | | e(a) and manner as stated. |
| TO THE HOSPI TO THE FUNER be filed within | TO BE | 296. SIGNATURE AND TITLE OF CENTIFIER 30. NAME AND ADDRESS OF PERSON WHO | digue M | TH (ITEM 27) (See | e Print) | 29c LICENSE NU | | | EO (Month, Day, Year) -21-90 |
| 6) | | Avigustos P / Rodr | iguez, M.D. | 5009 I | | Ct., Cam | p Springs, | Md. 207 | 48 |
| | | NOV 2 3 '90 | 32. REGISTRAR'S SIGNA | fandelle | | | | | |

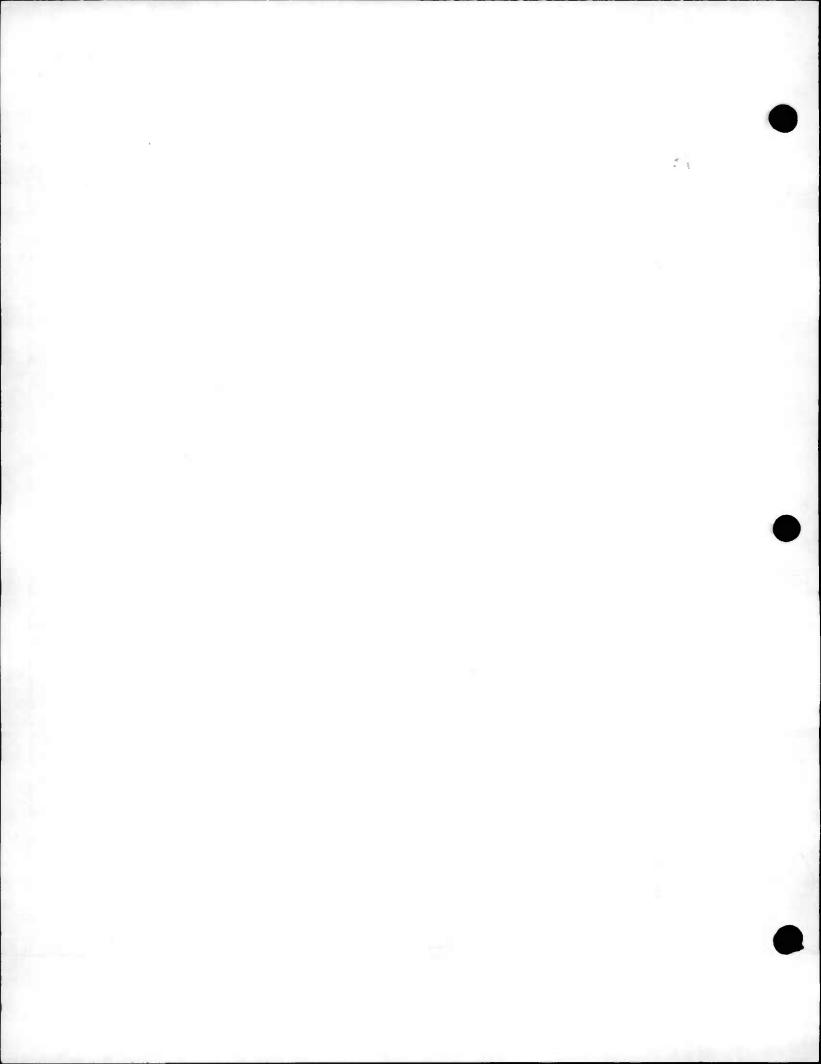


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| | THE CHATTENDING PHYSICIAN: The law requires that the death certificate be executed within | THE DIFFERENCE AND THIS CONTINUES CONTINUES TO BE SIGNED BY THE ATTENDING PHYSICIAN AND COMPletely |
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| | RAR | | CERTIF | | | | | | |
|--|--|---|---|---|--|--|---|---|---|
| 1. DECEDENT | 'S NAME (First, Middle, Last) | | | | | 2. DATE OF DE | DAY | EAR | ME OF DEATH |
| | aurice | | Jones | | | 1.1 | 22 9 | | 2:11 A |
| | CURITY NUMBER | 5. SEX 8. A | GE (In yrs. last birthday) | IF UNDER 1 YE | YS HOURS MIN. | 7. DATE OF BII (Month, Day, | Year) | BIRTHPLACE Country) | (Stata or Foreig |
| | 29-6751 | | YRS. | 3 2: | 2 | July 3 | | Mary1 | and |
| | NAME (If not institution, give si | | | 96. CITY, TO | WN OR LOCATION OF D | EATH | | OF DEATH | |
| S | outhern Mary | land Hospit | tal | | Clinton | | Prin | ce Geo | orge's |
| 10a. STATE | 10b. COUNTY | У | 10c. CI1 | TY, TOWN OR L | DCATION | | | 10d. | INSIDE CITY |
| Marv | land Prince | e George's | C1: | inton | | | | | YES 2 NO |
| | AND NUMBER | | | | 10f. ZIP COOE | | 10g. CITIZE | N OF WHAT | COUNTRY? |
| 5006 | Vienna Driv | ve | | | 20735 | | U.S. | Α. | |
| 11. MARITAL | STATUS | 12. WAS DECEOENT EVI | | | DECENDENT OF HISPA s, specify Cuban, Mexic | | | I. RACE — Ar Black, Whit | mericen Indien le, etc. |
| 1 | lerried 2 Married d 4 Divorced | IF YES, GIVE WAR O | | | YES ZXXNO Speci | | | Specify: | |
| | 15. DECEDENT'S EOU | CATION | 16a. DECEOENT'S | E HENAL OCCU | PATION | 165 KIND | OF BUSINESS/INDUS | Black | |
| | (Specify only highest grade | completed) | (Give kind of life. Do NOT | work done durin | g most of working | IOD. KING | OF BUSINESS/INDUS | | |
| Elementar | ny/Secondery (0-12) | College (1-4 or 5+) | Novembl | owlead | | i | | | |
| 17. FATHER'S | NAME (First, Middle, Last) | | NeverW | orked | 18, MOTHER'S N | AME (First, Middle, | Maiden Surname) | | |
| | Moses Jones | 3 | | | | cecia J | | | |
| 19e. INFORMA | ANT'S NAME (Type/Print) | | 19b. MAILIN | G AOORESS (St | reet and Number or Rural | | | ode) | |
| Moses | Jones | | 5006 | Vienna | Dr. Clin | ton MD | 20735 | | |
| 20e. METHOO | OF DISPOSITION | | | | of cemetery, crematory or | | 20c. LOCATION — CI | _ | tate |
| | 2 Cremation 3 Rem | oval from State | | Memor | ial Park | | Landover. | MD | |
| 21. SIGNATUR | RE OF FUTERAL SERVICE LI | CENSEE | 0 | 22. NA | ME AND ADDRESS OF F | ACILITY | | | |
|) | CLOAN. | MA C | 10 h /4 | | pert G. Ma | | | | |
| 22 PART I | . Enter the diseeses, or | complications that ca | #74 | | 51 Good Ho | De Rd | SE Wash | DC 7 | Approxime |
| disease or resulting is | | SDUE TO (OR | Sudden AS A CONSEQUENCE | | Death Sy | ndrome | | | |
| Sequential if any, less cause. Ent | iy iist conditions, ling to immediate er UNDERLYING | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| that initiate | sease or injury ed events n death) LAST | DUE TO (OR | AS A CONSEQUENCE | OF): | | | | | |
| | the all all the state of the | | ath hut not consisten | | | | | 1 | |
| | ther significant condition | IN CONTRIDUCING TO GE? | | | | n Darti I na- | WAS AN AUTODOY | 245 1000 | E VILLAUDOA LII |
| PARI II. O | | | an out not resulting | g in the unde | nying cause given i | | WAS AN AUTOPSY PERFORMED? | AWAII | LABLE PRIOR |
| | | | an but not resulting | g in the unde | nying cause given i | | | COM OF D | LABLE PRIOR ' PLETION OF C DEATH? |
| | E REFERRED TO MEOICAL | | - | | 26. PLACE OF DEATH (C | _ X | PERFORMED? | COM OF D | LABLE PRIOR ' PLETION OF C DEATH? |
| | | HOSPITAL: | | OTHER: | | Check only one) | PERFORMED? | COM OF D | LABLE PRIOR 1 PLETION OF G DEATH? |
| | ER? S 2 NO | HOSPITAL: 1 Inputient 2 ER | VOutpatient 3 □ DOA | OTHER: 4 Nursing | 26. PLACE OF OEATH (€) y Home 5 □ Residence | Check only one) | PERFORMED? | AMAI COM OF D | LABLE PRIOR 1 PLETION OF G DEATH? |
| 25. WAS CAS EXAMINI 1 VE: 27. MANNER 1 Noth | ER? 8 2 NO OF DEATH Irel 5 Pending | HOSPITAL: | VOutpatient 3 □ DOA | OTHER: 4 Nursing IME OF 28 NJURY 28 | 26. PLACE OF OEATH (C | Check only one) | PERFORMED? YES 2 NO pocify) | AMAI COM OF D | LABLE PRIOR 1 PLETION OF C DEATH? |
| 25. WAS CAS EXAMINI 1 YES | ER? 8 2 NO OF DEATH Irel 5 Pending Investigation ide 6 Could not be | HOSPITAL: 1 Inpetient 2 ER 28e. OATE OF INJ (Month, Day, Y | //Outpatient 3 □ DOA URY 26b. Ti fear) JURY — At home, ferm | OTHER: 4 Nursing | 26. PLACE OF OEATH (t) g Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO | Check only one) 6 Other (Sp. 28d. OESCRIE | PERFORMED?] YES 2 NO secify) BE HOW INJURY OCCU | AWAII COM OF E | LABLE PRIOR PLETION OF COPEATH? |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Nestu 2 Acci 3 Suic 4 Hom | ER? 8 2 NO OF DEATH Irel 5 Pending Investigation ide 6 Could not be | HOSPITAL: 1 Inpatient 2 Spen 28e. OATE OF INJ (Month, Day,) 28e. PLACE OF IN | //Outpatient 3 □ DOA URY 26b. Ti fear) JURY — At home, ferm | OTHER: 4 Nursing | 26. PLACE OF OEATH (t) g Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO | Check only one) 6 Other (Sp 28d. DESCRIE | PERFORMED?] YES 2 NO secify) BE HOW INJURY OCCU | AWAII COM OF E | LABLE PRIOR PLETION OF COPEATH? |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Nestu 2 Acci 3 Suic 4 Hom | ER? S 2 NO OF DEATH Iral 5 Pending Investigation lident Could not be determined | HOSPITAL: 1 Inpatient 2 Spen 28e. OATE OF INJ (Month, Day,) 28e. PLACE OF IN | UNITY 26b. Till URRY At home, ferm (Specify) | OTHER: 4 Nursing IME OF NJURY M | 26. PLACE OF OEATH (t) y Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO , office | Check only one) 6 Other (Sp 28d. DESCRIE 281. LOCATIO City or 70 | PERFORMED?] YES 2 NO BEHOW INJURY OCCI. N (Street and Number of Mrn., Stete) | JREO | LABLE PRIOR 1 IPLETION OF C JEATH? YES 2 N |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Nestu 2 Acci 3 Suic 4 Hom | ER? 2 NO OF DEATH Iral 5 Pending Investigation Idea 6 Could not be determined ER 1 CERTIFYING PHYS | HOSPITAL: 1 Inpetient 2 ER 28e. OATE OF INJ (Month, Day, Y) 28e. PLACE OF IN building, etc. | UVOutpetient 3 DOA URY 26b. T. III UURY At home, ferm (Specify) | OTHER: 4 Nursing IME OF NURY M n, street, factory | 26. PLACE OF OEATH (()) Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO , office | Check only one) 6 G Other (Sp 28d. DESCRIE 28f. LOCATIO City or To | PERFORMED?] YES 2 NO solly) BE HOW INJURY OCCU N (Street and Number of wird, Stele) | JREO AMAI COM OF to 1 JREO Ad. | LABLE PRIOR IPPLETION OF CIDENTIFY YES 2 |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Netu 2 Acci 3 Suic 4 Hon | ER? 2 NO OF DEATH Iral 5 Pending Investigation Idea 6 Could not be determined ER 1 CERTIFYING PHYS | HOSPITAL: 1 Inpstient 2 ER 28e. QATE OF INJ (Month, Day, ') 28e. PLACE OF IN building, etc. | UVOutpetient 3 DOA URY 26b. T. III UURY At home, ferm (Specify) | OTHER: 4 Nursing IME OF NURY M n, street, factory | 26. PLACE OF OEATH (to g Home 5 Residence ic. INJURY AT WORK? 1 YES 2 NO , office No , date and place, and d alon, death occursed at it | 28d. OESCRIE 28d. OESCRIE 28d. LOCATIO City or 70 use to the cause(e the lime, date and | PERFORMED?] YES 2 NO socily) BE HOW INJURY OCCU N (Street and Number of wird, Stele)] end manner as state place, and due to the | JREO JREO O COUSS(e) and SIGNED (Mor | Number, |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Acci 2 Acci 3 Suic 4 Horn 296. CERTIFI | ER? S 2 NO OF DEATH arei 5 Pending Investigation bide 6 Could not be determined ER 1 CERTIFYING PHYS MEDICAL EXAMIN | HOSPITAL: 1 Inpstient 2 ER 28e. QATE OF INJ (Month, Day, ') 28e. PLACE OF IN building, etc. | UVOutpetient 3 DOA URY 26b. T. III UURY At home, ferm (Specify) | OTHER: 4 Nursing IME OF NURY M n, street, factory | 26. PLACE OF OEATH (C) Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO c, office b, date end place, end d | 28d. OESCRIE 28d. OESCRIE 28d. LOCATIO City or 70 use to the cause(e the lime, date and | PERFORMED?] YES 2 NO socily) BE HOW INJURY OCCU N (Street and Number of wird, Stele)] end manner as state place, and due to the | JREO JREO d. | Number, Id manner ee st |
| 25. WAS CAS EXAMINI 1 YES 27. MANNER 1 Nettle 2 Acci 3 Sulc 4 Hon | ER? S 2 NO OF DEATH arei 5 Pending Investigation bide 6 Could not be determined ER 1 CERTIFYING PHYS MEDICAL EXAMIN | HOSPITAL: 1 Inpatient 2 LER 28e. OATE OF INJ (Month, Day,) 28e. PLACE OF IN building, etc. SICIAN: To the best of my IER: On the basic of exam | UNUtpatient 3 DOA URY 28b. Till (Specify) knowledge, death occulination end/or investigation | OTHER: 4 Nursing IME OF NJURY M 1, street, factory arred at the time | 26. PLACE OF OEATH (to g Home 5 Residence ic. INJURY AT WORK? 1 YES 2 NO , office No , date and place, and d alon, death occursed at it | Check only one) 6 Other (Sp 28d. DESCRIE 281. LOCATIO City or 70 ue to the ceuse(e he lime, date and | PERFORMED?] YES 2 NO ecity) BE HOW INJURY OCCU N (Street and Number of vari, State) end manner as state place, end due to the 29d. DATE 1 | JREO JREO AMAR OF TO TAX JREO A Rural Route d. Couse(e) and SIGNED (Mor. 1/22/ | Number, Number, I manner ee si |
| 25. WAS CAS EXAMINI 1 VE: 27. MANNER 1 Note 2 Acci 3 Suic 4 Hon | ER? S 2 NO OF DEATH Iral 5 Pending Investigation Could not be determined EER 1 CERTIFYING PHYS MEDICAL EXAMIN | HOSPITAL: 1 Inpstient 2 ER 28e. QATE OF INJ (Month, Day,) 28e. PLACE OF IN building, etc. SICIAN: To lihe best of my IER: On lihe basic of exam | Unity 26b. T. III UNITY 26b. T. III UNITY — At home, ferm (Specify) knowledge, death occulination end/or investiga | OTHER: 4 Nursing IME OF NJURY M 1, street, factory arred at the time | 26. PLACE OF OEATH (t) y Home 5 Residence c. INJURY AT WORK? 1 YES 2 NO , office i. date end place, end d alon, death occured at it 29c. LICENSE N COME | Check only one) 6 Other (Sp 28d. DESCRIE 281. LOCATIO City or 70 ue to the ceuse(e he lime, date and | PERFORMED?] YES 2 NO socily) BE HOW INJURY OCCU N (Street and Number of wird, Stele)] end manner as state place, and due to the | JREO JREO AMAR OF TO TAX JREO A Rural Route d. Couse(e) and SIGNED (Mor. 1/22/ | Number, Number, I manner ee s |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE



| BALTIMORE, MARYLAND 21203-3146 | 4 nours after death. Page 6 may be retained by the hospital or attending physician. Miled in by the funeral director, page 5 should be detached for use as the burial-transit p. or removal. | e medical examiner must be notified at once. |
|--|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hydele prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| REGISTRAR | | C | ERTIF | CATE (| OF DEATH | MILIT | REG. NO | L | | | |
|---|--|-------------------------|----------------------------|------------------------------|------------------------|------------|---------------------|-----------------|-------------|---------------------------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | TI. | 0 | | | ATE OF DEATH | | 3. | . TIME OF DEATH | _ |
| | abeth | | 1 | 100 | RA | M. | 11- 2 | 2 ~ | YEAR YOU | 2:30a | h |
| 4. SOCIAL SECURITY NUMBER | | AGE (In yrs. la | st birthday) | IF UNDER 1 YE | | 7. D | TE OF BIRTH | | 8. BIRTHPL | ACE (State or Foreign | |
| 198-34-9165 | 1 🗌 M 2 🚇 F | 83 | YRS. | MONTHS DA | YS HOURS MIN | | 10/30/0 | 7 | Country) | sylvania | |
| Ga. FACILITY NAME (If not Institution, give s | street and number) | | | 9b. CITY, TO | WN OR LOCATION OF | | 10,00,0 | _ | TY OF DEAT | - | _ |
| 123 St. Andrews Re | oad | | - | Son | erna Par | 1,- | | | | | |
| RESIDENCE OF DECEDENT | | | | DC. | VELTIA FAI | <u>K</u> | | Ani | ne Ar | undel | _ |
| 10a. STATE 10b. COUNT | | | 10c. CIT | , TOWN OR L | OCATION | | | | 10 | Dd. INSIDE CITY | _ |
| PA North | Umberland | | Mou | int Car | me1 | | | | 1 | LIMITS? | |
| 10e. STREET AND NUMBER | | | | | 10f. ZIP CODE | | | 10g. CITIZ | | T COUNTRY? | _ |
| 43 North Hickory S | Street | | | | 1785 | 1 | | log. cirila | | a cooming | |
| 11. MARITAL STATUS | 12. WAS DECEDENT E | VER IN U.S. AF | MED | 13. WAS | DECENDENT OF HIS | | IGIN2 (Pacally Vos | an No. | USA | | _ |
| 1 Never Merried 2 Married | FORCES? 1 [| YES 2 Z | МО | IT yes | i, specify Cuban, Mex | icen, Puar | rto Ricen, etc.) | or No 1 | Black, W | Amaricen Indian, /hite, etc. | |
| 3 ☑ Widowed 4 □ Divorced | ii reo, dive wan | OH DATES | | ן יי | YES 2 XNO Spe | ecify; | | | Specify: | white | |
| 15. DECEDENT'S EDU | CATION | 16e, DE | CEDENT'S | USUAL OCCU | PATION | | 16b. KIND OF BUS | INERG (IND) | | | _ |
| (Specify only highest grade Elementery/Secondary (0-12) | College (1-4 or 5+) | (G | ive kind of w Do NOT us | rork done durin retired.) | most of working | | ios. King of Bos | MESSINDO | SINT | | |
| 12 | Contage (1-4 of 5 +) | | Homo | maker | | | | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | TRANC | maker | 40 1107117010 | | | Home | | | |
| William W. Andrews | 7 | | | | | | st, Middle, Maiden | Surname) | | | |
| 190. INFORMANT'S NAME (Type/Print) | | | | | Edna 1 | | | | | | |
| | | 19 | | | eet and Number or Rur | al Route N | umber, City or Town | n, State, Zip C | Code) | | |
| Mrs. Ruth E. Barre | ett | | | as # | | | | | | | |
| 20e. METHOD OF DISPOSITION 1 1 Burlet 2 □ Cremetion 3 □ Remo | oval from State | 20b. PLACE other pic | OF DISPOS | ITION (Name o | cemetery, crematory of | or | 20c. LO | CATION - CI | ty or Town, | Slata | |
| 4 Donetion 5 Other (Specify) | 7297 | St. | Ĵose | ph's C | emetery | | Four | ntaine | Spr | ingspa | |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | | 1 | 22. NAM | E AND ADDRESS OF | FACILITY | | | | 35.54 | _ |
| · Kolus | 1 | | | Bar | ranco & S | Sons | Funeral | . Home | ; | | |
| 77-000 | - | ~~~ | 1. | 495 | Ritchie | Hwy. | Severn | a Par | k, MI | 21146 | |
| 23. PART I. Enter the diseesea, or o shock, or heert failure. | complications that callet only one ceuse | aused the de | th. Do n | ot enter the | mode of dying, a | uch as c | ardiac or respin | ratory erres | st, | Approximate | |
| IMMEDIATE CAUSE (Finel | 1 | | ~ | | | | | | | Oneet and Deet | |
| disease or condition resulting in deeth) | . 64 | 49 | C, | ahci | 25 | | | | | | |
| | DUE TO (OF | ASA CONSEC | DUENCE OF | : | | | | | | | _ |
| | | | | | | | | | | İ | |
| Sequentially list conditions, if eny, leading to immediate | DUE TO (OF | AS A CONSEC | UENCE OF | : | | | | | | | _ |
| ceuee. Enter UNDERLYING | | | | | | | | | | | |
| CAUSE (Disease or injury that initieted events | DUE TO (OF | AS A CONSEC | UENCE OF | : | | | | | | | _ |
| resulting in death) LAST | | | | | | | | | Ì | | |
| | | | | | | | | | | | |
| PART II. Other algorificent conditions | contributing to de | ath but not re | esulting In | the underl | ing ceuse given i | n Part i. | | | 24b. WE | RE AUTOPSY FINDINGS | 5 |
| | | | | | | | PERFORI | | | MILABLE PRIOR TO MPLETION OF CAUSE | |
| | | | | | | | 1 TYES 2 | NO | | DEATH? | |
| | | | | | | _ | | | 1 [| YES 2 NO | |
| 25. WAS CASE REFERRED TO MEDICAL | | | | | | | | | | | |
| EXAMINER? | HOSPITAL: | | | OTHER: | PLACE OF DEATH (| check only | one) | | | | _ |
| 1 YES 2 NO | 1 Inpetiant 2 I EF | | | I ☐ Nursing I | ome 5 Reeldence | 6 🗆 Ot | her (Specify) | | | | |
| 27. MANNER OF DEATH | 28e. DATE OF INJ (Month, Day,) | | 28b. TIME INJU | OF 28c. | INJURY AT WORK? | 28d. D | EȘCRIBE HOW IN | JURY OCCU | RED | | _ |
| 1 Natural 5 Pending 2 Accident Investigation | | | | | YES 2 NO | | | | | | |
| 3 Suicide 6 Could not be | 28s. PLACE OF IN building, etc. | JURY — At hon | ne, farm, ati | eet, fectory, o | ffice | 28f. LC | CATION (Street an | nd Number or | Rural Route | Number, | _ |
| 4 Homicide datermined | | (opocny) | | | | C | ty or Town, State) | | | | |
| 290. CERTIFIER CERTIFYING PHYSIC | IAN: To the best of my | knowledge de- | | | | | | | _ | | _ |
| (Check only one) 2 MEDICAL EXAMINER | SAN: To the beat of my | netion end/or in | an occurred | at Jhe Jime, d | ele end place, and du | e to the c | euse(e) end menn | er ea stated. | | | |
| | : On the basie of axami | mation end/or ir | ivestigation, | In my opinior | , death occured at Ih | e time, da | ita end plece, end | due to the c | euse(e) and | f menner ee atated. | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | 21 0 | 1 | | | 29c. LICENSE NU | | | 29d. DATE S | IGNED (Mor | nth, Day, Year) | _ |
| ager | 000 | oly | | | 027 | 83 | 8 | D // | //2 | 8/80 | |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE O | F DEATH (ITEM | 27) (Туре, Р | rint) | | | | | | | - |
| 31. DATE FILED (Month), Daniero | -0-5a] | 2000 | 9 | 5 1 | guah | a=7 | - Rd | 614 | ~ B | المراج ما |) |
| DFC 114 1990 90 | ia isussissisme | TIGNATURE | | | 17 | | | | | | ٦ |

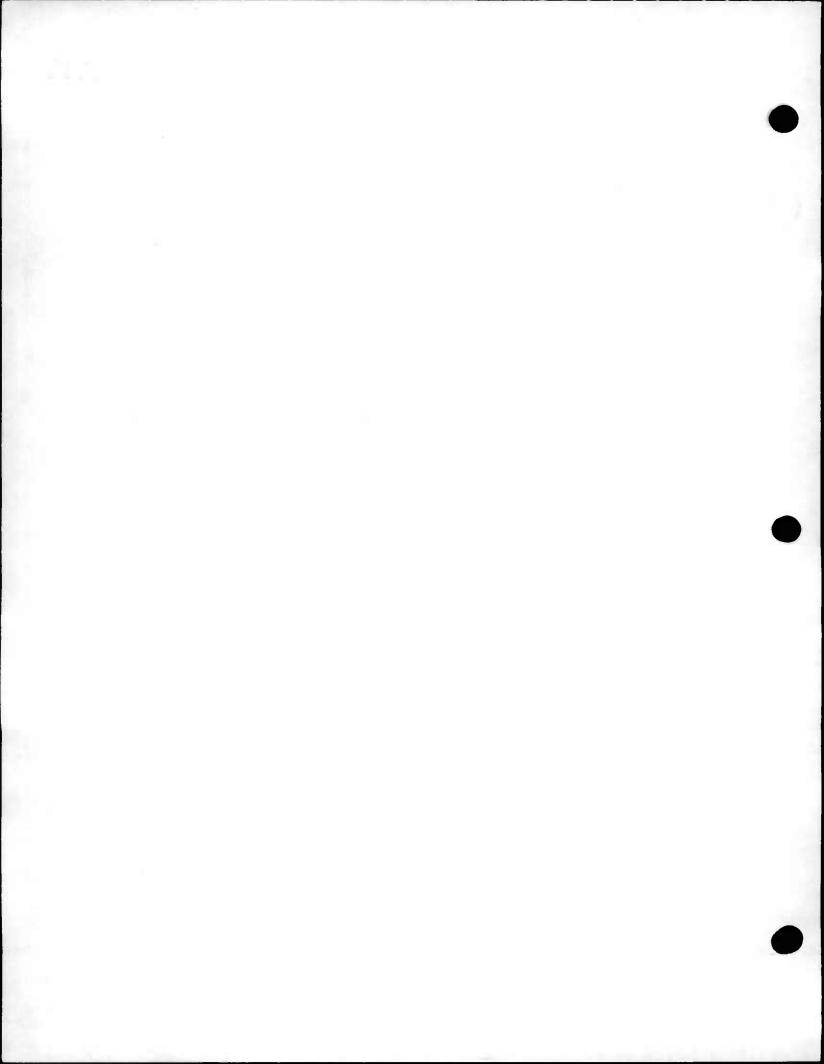
p · n

| | þ |) |
|--|--|---|
| BALTIMORE, MARYLAND 21203-3146 | I DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-, nours after death. Page 6 may be retained by the hospital or attending physician. | DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. |
| 13146, | executed within | and completel |
| BOX | tificate be e | g physician |
| P.O. | death cert | attending |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | w requires that the c | s been signed by the |
| VITAL | CIAN: The Is | ertificate has |
| NO N | G PHYS | er this c |
| DIVISION | DR ATTENDIN | DIRECTOR: Aft |

TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within 2~ ...ours after death. Page 6 may be retained by the hospital or TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for up filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| | FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. |
|---------------|--|
| | |
| ľ | Iris Jones 12 6 90 3 4 " |
| | 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lost birthday) F UNDER 1 VEAR F UNDER 24 HRS. 1. DATS HOURS MIN. 216 - 36 - 0015 1 M 2 & F 5 2 YRS. MONTHS DAYS HOURS MIN. 225 - 37 Country D. C. |
| | 216-36-0015 1 M 2 KF 52 YRS. MONTHS DAYS HOURS MIN. 12-25-37 D.C. 96. FACILITY NAME (If not institution, give street end number) 96. COUNTY OF DEATH 96. COUNTY OF DEATH |
| œ | ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL |
| 6 | RESIDENCE OF DECEDENT |
| DIRECTOR | LIMITS? |
| | MARYLAND ANNE ARUNDEL ANNAPOLIS 1 Tes 2 No 109. STREET AND NUMBER 109. CITIZEN OF WHAT COUNTRY? |
| RA | 1140 MADISON ST. APT. S1 21403 U.S.A. |
| FUNERAL | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECEMBENT OF HISPANIC ORIGIN? (Specify Yee or No— Black, White, etc.) 14. RACE — American Indian, Black, White, etc. |
| BY F | 1 Never Merried 2 Merried FORCES? 1 YES 2 NO If yes, specify Cuben, Maxicon, Puerto Ricen, atc.) Black, white, etc. Specify: B L A C K |
| | 15. DECEDENT'S EDUCATION 168. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY |
| 13 | (Specify only highest grade completed) (Give kind of work done during most of working life, Do NOT use retired,) |
| 19 | Elementary/Secondary (0-12) College (1-4 or 5+) CENERAL CHEIF |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| BE | JAMES JOHNSON, SR. ANNABELL PINKNEY |
| 2 | 190. INFORMANT'S NAME (Type/Print) 190. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEON JONES 1140 MADISON ST. APT. S1 ANNAPOLIS, MD, 2140 |
| | 20s. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State |
| | 1 Buriel 2 M Ervination 3 D Removal from State 4 Donetion 5 D Other (Specify) |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY 8 2 1 WEST ST. ANN APOLIS, |
| | Lovy & Jees REESE & SONS MORTUARY, P.A. |
| | 23. PART I. Enter the diseases, or complicatione that caused the death. Do not anter the mode of dying, auch se cerdiac or respiratory arrest, shock, or heart fellure. List only one cause on each line. Approximate Interval Batween |
| | IMMEDIATE CAUSE (Final |
| | resulting in death) a. A DULL KITS INSTITUTE OF THE TO GO AS A CONSECUTION OF THE TO GO AS A CO |
| _ | - LUNG CANCER |
| 0 | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): |
| S | CAUSE (Please or Infun) |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST |
| SE . | d. |
| CAL | PART II. Other algorificent conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PINDINGS ANALLABLE PRIOR TO COMPLETION OF CAUSE |
| EDIC | 1 YES 2 NO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO 1 YES 2 NO |
| Σ | 1 1 125 2 1 110 |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) |
| Sic | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Input lent 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) |
| £ | 27. MANNER OF DEATH 26e. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY WORK? 28d. DEŞCRIBE HOW INJURY OCCURED |
| BY | 1 Netural 5 Pending M 1 YES 2 NO Investigation 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, |
| ED | 3 Suicide 6 Could not be building, stc. (Specify) City or Town, State) |
| COMPLETED | 29a. CERTIFIER 1 CERTIFYING PHYSICIAN. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated. |
| M | (Check only one) 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(e) end manner as stated. |
| | 296. SIGNATURE AND TITLE OF CERTIFIER A 29c. LICENSE NUMBER 29d. DATE SIGNED/(Month, Day, Year) |
| O BE | Gorald C. Roans, 7.D. 010678 11/6/90 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) DONALD C. ROTHE M.D. 16/6 FOREST DRIVE ANNIPOLIS 21403 |
| | DEC 0 7 1990 July Davidson Randage |



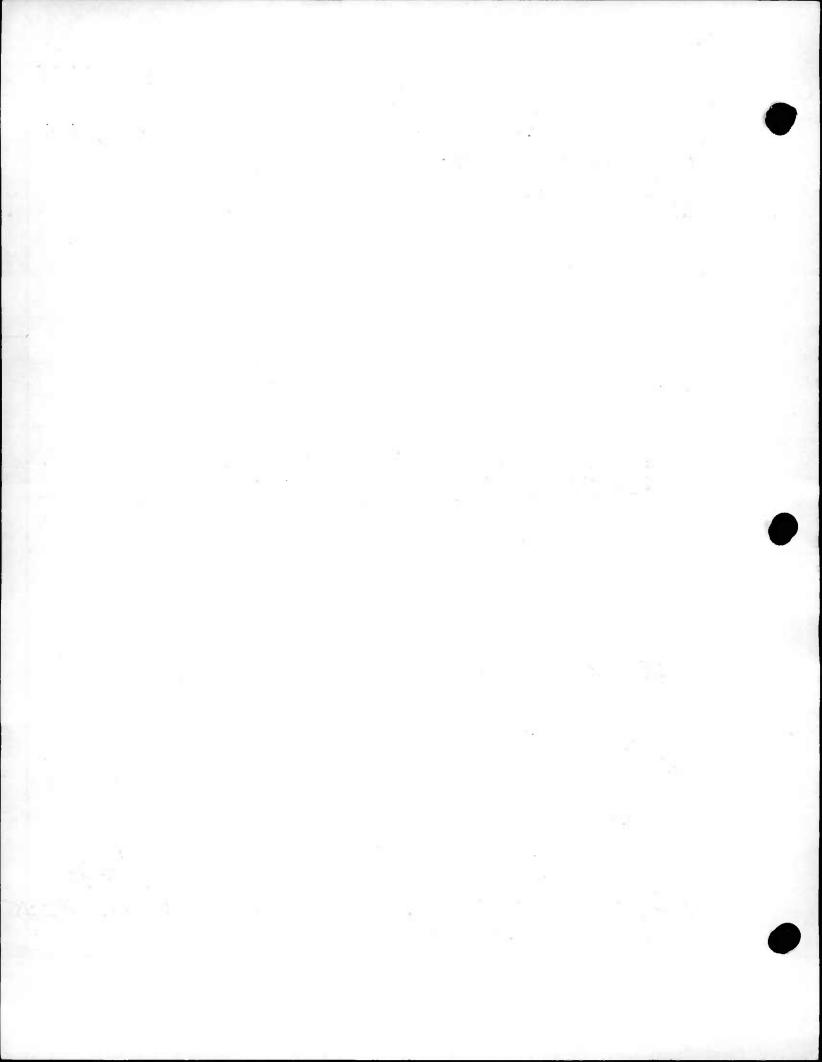
| n 24 mours after death. Page 6 may be retained by the hospi | by filled in by the funeral director, page 5 should be detached ation, or removal. | the medical examiner must be notified at once. |
|--|---|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospi | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached a completely filled in by the funeral director, page 5 should be detached a complete the state has been with the State pent of Health and Mental Hydiens brids to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

31. DATE FILED (Month, Day, Ye

| | 1 - FOR STATE REGISTRAR | | STATE OF MA | | | TMENT OF H | | | YGIENE EG. NO. | | 0 0 14 14 | |
|------------------------------------|--|--|--|--|---|---|--|--|---|--|--|----------------|
| | 1. DECEDENT'S NAME (First | , Middle, Last) | | | | | | 2. DATE OF D | DEATH DAY | YEAR | 3. TIME OF DEATH | |
| | CHARI | LES I | MILLARD | KINNA | NOMA | JR. | | 1 1 1 | 25 | 1990 | 655m | M |
| | 4. SOCIAL SECURITY NUME | BER | 5. SEX 6. | AGE (In yrs. las | st birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | HETH | 6. BIF | THPLACE (State or Foreigntry) | ign |
| 1 | 214-07- | 7049 | 1 M 2 🗆 F | 85 | YRS. | MONTHS DAYS | HOURS MIN. | 07 | 2 19 | 05 1 | Maryland | |
|) | 90. FACILITY NAME (ti not in | | street and number) | 92 | | 9b. CITY, TOWN C | OR LOCATION OF DE | | | COUNTY OF | | |
| No. | Dorches | | General 1 | Hosp. | | Camb | oridge | | D | orche | ester | |
| EC | 10e. STATE | 10b. COUNT | Υ | | 10c. CITY | , TOWN OR LOCAT | TION | | | | 10d. INSIDE CITY | |
| FUNERAL DIRECTO | MD. | Do | orcheste: | r | | Cambrid | lge | | | | NYES 2 N | 0 |
| - | 10e. STREET AND NUMBER | | | | | 101 | I. ZIP CODE | | 10 | g. CITIZEN O | F WHAT COUNTRY? | |
| 7 | 305 B | havie | ere Ave. | | | | 2161 | 3 | | U. | S.A. | |
| Ž. | 11, MARITAL STATUS | JI V Ca. | 12. WAS DECEDENT I | EVER IN U.S. AF | RMED | 13. WAS DEC | ENDENT OF HISPAI | NIC ORIGIN? (S | pecify Yee or I | | ACE — Americen Indien lack, White, etc. | ١, |
| 正 | 1 Never Merried 2 | Merried | FORCES? 1 IF YES, GIVE WAF | | NO | | ecity Cuben, Mexice 2 NO Specif | | | | beck, White, etc. | |
| ВУ | 3 Widowed 4 Dive | orced | 11 723, 0172 1017 | ON DAILS | | 1 723 | XXIII SACON | y MAX | K 65 | " | will te | |
| Ω | 15, DEC | EDENT'S EDU | ICATION | 16e. DE | ECEDENT'S | USUAL OCCUPATION | ON | 16b. KIN | ID OF BUSINE | SS/INDUSTR | 1 | |
| E 1 | (Specify on Elementary/Secondary (| ly highest grade | College (1-4 or 5 +) | | | vork done during mo e retired.) | | | | | | |
| 7 | 10 | , | | in | sura | nce sal | lesman, | barb | er- S | tate | of Md. | |
| COMPLETED | 17. FATHER'S NAME (First, A | Aiddle, Last) | | | | | 16. MOTHER'S NA | ME (First, Middl | le, Malden Sum | name) | | |
| Ö | Charle | as Mi | llard Ki | ກກລຫດເ | n | | Ve | rdona | Hur | lev | | |
| BE | 19e. INFORMANT'S NAME (| | IIUIU KI | | | ADDRESS (Street I | and Number or Rural | | | _ | | |
| 2 | Lucy S. | | amon | | | | ere Ave | | | | | |
| | 20a, METHOD OF DISPOSIT | TION | AND THE STATE OF T | 20b. PLACE | OF DISPOS | SITION (Name of ce | metery, cremetory or | | | ION — City o | | |
| | Mauriel 2 ☐ Cremetic | | noval from State | ether p | New | Market | Cemete | rv | E.N | lew Ma | arket Md | |
| | 21. SIGNATURE OF TUNEFUL | | ČENSEE | | | | ND ADDRESS OF FA | | | | | |
| | · //V . | -1 |) | | | | | 'I'n | | | ral Home | |
| | Stal | ال (ب | Touth | | | 700 | Locust | st. C | ambri | .dge 1 | Md.21613 | |
| | 23. PART i Enter the c | | complications that | | | not enter the mo | oda of dylng, euc | ch ae cardiac | or respirate | ory arreat, | Approximat | |
| | gillock, of i | ideit tendie. | | | • | | | | | | | |
| | IMMEDIATE CAUSE (FI | nai | | | | 1 | | Λ | | | Onset and | Death |
| | immediate cause (Fi | nai | | | ral | Vasco | ler K | Jack | est | | Onset and | Death |
| | | inal — | | | EQUENCE OF | Vascu | ler K | Jac. E | est. | | Onset and | Death |
| Z | dieeesa or condition resulting in deeth) | → | | | EQUENCE OF | Vascu Mi | ler A | Accid | Car | nd a | Onset and | Death |
| NOI | dieeeaa or condition | tions, | | | EQUENCE OF | Vascu Pi | ler A | Accison as à | Can | nd a | Onset and | Death (|
| CATION | dieeea or condition resulting in deeth) Sequentially list condition, leading to immiceuse. Enter UNDERLY | tions, addete | | | EQUENCE OF | Vasco | Deter A | Accibo | Car. | nd a | Onset and 2 de | Death |
| IFICATION | dieeeaa or condition resulting in deeth) Sequentially list condition, leading to immiceuse. Enter UNDERLY CAUSE (Disease or in) that initiated events | tions, addete //ING | a. DUE TO (C | | EOUENCE OF | Vascu | der A | Accis ais R Por | Car. | nd a | Onset and | Death only (|
| ERTIFICATION | dieeea or condition resulting in deeth) Sequentially list condit eny, leading to imm ceuse. Enter UNDERLY | tions, addete //ING | a. DUE TO (C | DR AS A CONSE | EQUENCE OF | Vascu | der A | Accide | Car Tiple | nd a | Onset and 2 dc | Death |
| CERTIFICATION | Sequentially list condition resulting in death) Sequentially list condition, leading to immiceuse. Enter UNDERU, CAUSE (Disease or in) that initisted events resulting in death) LA: | tions, adjete ring ury | a. DUE TO (C DUE TO (C C. DUE TO (C | DR AS A CONSE | EOUENCE O | F): | | | | | 2 de | N. |
| ÄL | Sequentially list condition resulting in deeth) Sequentially list condition, leading to immuceuse. Enter UNDERLY CAUSE (Disease or injust that initisted events resulting in death) LAS | tions, addete /iNG ury | a. DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | EOUENCE O | F): | | | Cart Cart Cart Cart Cart Cart Cart Cart | TOPSY | 2 de Joseph January Fin Available Prior T | oney (|
| ÄL | Sequentially list condition resulting in deeth) Sequentially list condition, leading to immuceuse. Enter UNDERLY CAUSE (Disease or injust that initisted events resulting in death) LAS | tions, adjete ring ury | a. DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | EOUENCE O | F): | | n Part i. 24 | a, WAS AN AU | TOPSY | 2 de | oney (|
| ÄL | Sequentially list condition resulting in deeth) Sequentially list condition, leading to immuceuse. Enter UNDERLY CAUSE (Disease or injust that initisted events resulting in death) LAS | tions, addete /iNG ury | a. DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | EOUENCE O | F): | | n Part i. 24 | a. WAS AN AU | TOPSY | 2 dl. 24b. WERE AUTOPSY FIN ANALABLE PRIOR T COMPLETION DF CI. | IDINGS TO AUSE |
| ÄL | Sequentially list condition resulting in deeth) Sequentially list condition, leading to immuceuse. Enter UNDERLY CAUSE (Disease or injust that initisted events resulting in death) LAS | tions, addete /iNG ury | a. DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | EOUENCE O | F): | | n Part i. 24 | a. WAS AN AU | TOPSY | 2 dl. 24b. WERE AUTOPSY FIN ANILABLE PRIOR T COMPLETION DF CA DF DEATH? | IDINGS TO AUSE |
| ÄL | dieeeaa or condition resulting in deeth) Sequentially list condition, leading to immuceuse. Enter UNDERLY CAUSE (Disease or injust initiated events resulting in death) LA: PART II. Other alignific | tions, addete /ING urry ST | a. DUE TO (C DUE TO (C d | DR AS A CONSE | EOUENCE O | in the underlyin | | 1 Part I. 24 | a. WAS AN AU | TOPSY | 2 dl. 24b. WERE AUTOPSY FIN ANILABLE PRIOR T COMPLETION DF CA DF DEATH? | IDINGS TO AUSE |
| ÄL | dieeeaa or condition resulting in deeth) Sequentially list condition, leading to immiceuse. Enter UNDERLY CAUSE (Disease or injust initisted events resulting in death) LA: PART II. Other alignific | tions, addete /ING urry ST | a. DUE TO (C DUE TO (C DUE TO (C | PR AS A CONSE | reaulting | in tha undarlyin | ng ceuse given in | 1 Part I. 24 | a. WAS AN AUPPERFORME | TOPSY | 2 dl. 24b. WERE AUTOPSY FIN ANILABLE PRIOR T COMPLETION DF CA DF DEATH? | IDINGS TO AUSE |
| ÄL | dieeeaa or condition resulting in deeth) Sequentially list condition, resulting in deeth list conditions, l | tions, addete /ING urry ST | a. DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | reaulting 3 □ DOA 28b. Till | in the underlying 26. F | ng couse given in | 1 Part i. 24 1 1 heck only one) 6 □ Other (S | a. WAS AN AUPPERFORME | TOPSY D? | 2 dl. 24b. WERE AUTOPSY FIN AWAILABLE PRIOR T COMPLETION DF CU DF DEATH? 1 YES 2 N | IDINGS TO AUSE |
| PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting to immiceuse. Enter UNDERLY CAUSE (Dieeese or in) that initisted events resulting in death) LA: PART II. Other alignific PART II. Other alignific EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 | tions, addete /ING urry ST | a. DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C DUE TO (C | DR AS A CONSE | reaulting 3 □ DOA 28b. Till | in the underlyin 26. P OTHER: 4 Nursing Hori BE OF 28c. IN WRY W | ng couse given in | 1 Part i. 24 1 1 heck only one) 6 □ Other (S | a. WAS AN AU PERFORME YES 2 | TOPSY D? | 2 dl. 24b. WERE AUTOPSY FIN AWAILABLE PRIOR T COMPLETION DF CU DF DEATH? 1 YES 2 N | IDINGS TO AUSE |
| BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in leading to immiceuse. Enter UNDERLY CAUSE (Dieeese or in) that initisted events resulting in death) LA: PART II. Other alignific PART II. Other alignific EXAMINER? 1 YES 2 NO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 CACIDENT | tions, addete ring array street ring ant condition of the | B. DUE TO (C DUE TO (| PR AS A CONSE | resulting 3 DOA 28b. TIM | in the underlyin 26. P OTHER: 4 Nursing Hori BE OF 28c. IN WRY W | PLACE OF DEATH (Come 5 Greeidence JURY AT ORK? YES 2 NO | heck only one) 6 Other (S 26d. DESCR | PERFORME YES 2 Pecify) IBE HOW INJU | TOPSY ED? NO | 2 dl. 24b. WERE AUTOPSY FIN AWAILABLE PRIOR T COMPLETION DF CU DF DEATH? 1 YES 2 N | IDINGS TO AUSE |
| BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in leading to immiceuse. Enter UNDERLY CAUSE (Dieeese or in) that initisted events resulting in death) LA: PART II. Other alignific PART II. Other alignific EXAMINER? 1 YES 2 NO 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 CACIDENT | tions, addete ring ury ST ant condition TO MEDICAL | B. DUE TO (C DUE TO (| PR AS A CONSE | resulting 3 DOA 28b. TIM | 28. F OTHER: 4 Nursing Horl JURY M 1 | PLACE OF DEATH (Come 5 Greeidence JURY AT ORK? YES 2 NO | heck only one) 6 Other (S 26d. DESCR | e. WAS AN AUTPERFORME YES 2 Pecify) IBE HOW INJU | TOPSY ED? NO | 2 db. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION OF CO DF DEATH? 1 YES 2 N | IDINGS TO AUSE |
| BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in deeth list cause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAI PART II. Other algnific PART II. Other algnific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER DEATH 1 Netural 5 2 2 Accident 3 Suicide 6 4 Homicide | tions, addite (ring ury) ant conditio To MEDICAL Pending Investigation Could not be determined | B. DUE TO (C DUE TO (| PR AS A CONSE OR AS A CONSE OR AS A CONSE Injury — At h | resulting 3 DOA 29b. Till IN. | 26. P OTHER: 4 Nursing Hot BURY W M 1 street, factory, offi | PLACE OF DEATH (Come 5 Green Residence JURY AT ORK? YES 2 NO | 1 Part i. 24 1 1 1 Other (S) 28d. DESCR 28f. LOCATIC City or 1 | a. WAS AN AUTPERFORME YES 2 pecify) IBE HOW INJU ON (Street and fown, State) | TOPSY D? NO URY OCCURE | 2 db. WERE AUTOPSY FIN AMAILABLE PRIOR TO COMPLETION OF CO DF DEATH? 1 YES 2 N | IDINGS TO AUSE |
| BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in deeth list cause. Enter UNDERLY CAUSE (Disease or in that initisted events resulting in death) LAS PART II. Other alignific PART II. Other alignific EXAMINER? 1 | tions, addate //ING ury sant condition of the condition o | B. DUE TO (C DUE TO (| PR AS A CONSE OR AS | resulting 3 DOA 28b. TIM IN. | 26. F OTHER: 4 Nursing Hor IE OF URY W 1 Street, factory, offi | PLACE OF DEATH (Come 5 Greendence JURY AT ORK? YES 2 NO ce | heck only one) 6 Other (S) 26d. DESCR 28f. LOCATIC City or 1 | e. WAS AN AUTPERFORME YES 2 pecify) IBE HOW INJU ON (Street and fown, State) | TOPSY ED? NO URY OCCURE Number or Re | 2 db. Were autopsy fin Analusus Prior to Completion of Country of Death? 1 Yes 2 N | IDINGS TO AUSE |
| PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list conditif eny, leading to immiceuse. Enter UNDERLY CAUSE (Disease or in) that initisted events resulting in death) LA: PART II. Other algnific PART II. Other algnific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturel 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only) 2 | tions, addete ring and conditions. To MEDICAL Pending Investigation Could not be determined TIFYING PHYSIDEAL EXAMIN | a. DUE TO (C DUE TO | PR AS A CONSE OR AS | resulting 3 DOA 28b. TIM IN. | 26. F OTHER: 4 Nursing Hor IE OF URY W 1 Street, factory, offi | PLACE OF DEATH (Come 5 Residence JURY AT ORK? YES 2 NO ce te end plece, end du death occured at th | 1 Part i. 24 1 1 6 Other (S 28d. DESCR 28f. LOCATIN City or 1 | e. WAS AN AUPPERFORME YES 2 Pecify) IBE HOW INJU ON (Street and down, State) (e) and menne d place, and d | TOPSY ED? NO URY OCCURE Number or Ru or as stated. | 2 dl. 24b. WERE AUTOPSY FIN ANALABLE PRIOR T COMPLETION DF CL DF DEATH? 1 YES 2 N N Neel (e) end menner ee ste | IDINGS TO AUSE |
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| BE COMPLETED BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in death Later PART II. Other algnific PART II. Other algnific PART II. Other algnific 25. WAS CASE REFERRED EXAMINER? 1 | tions, addete ring ury street record ring ury street record ring record ring record ring ring ring ring ring ring ring ring | B. DUE TO (C DUE TO (| PR AS A CONSE | reaulting 3 DOA 28b. Till IN. nome, farm, | 26. P OTHER: 4 Nursing Hor IE OF 28c. IN JURY M 1 street, factory, offi | PLACE OF DEATH (Come 5 Residence JURY AT ORK? YES 2 NO ce le end place, end du death occured at th | 1 Part i. 24 1 1 6 Other (S 28d. DESCR 28f. LOCATIN City or 1 | e. WAS AN AUPPERFORME YES 2 Pecify) IBE HOW INJU ON (Street and down, State) (e) and menne d place, and d | TOPSY ED? NO URY OCCURE Number or Ru or as stated. | 2 dl. 24b. WERE AUTOPSY FIN ANALABLE PRIOR T COMPLETION DF CL DF DEATH? 1 YES 2 N N Neel (e) end menner ee ste | IDINGS TO AUSE |
| E COMPLETED BY PHYSICIAN: MEDICAL | dieeeaa or condition resulting in deeth) Sequentially list condition resulting in deeth) Sequentially list condition resulting in death that resulting in death LA: PART II. Other alignific PART II. Other alignific 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Naturel 5 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER (Check only 1 CERTIF | tions, addete ring ury street record ring ury street record ring record ring record ring ring ring ring ring ring ring ring | B. DUE TO (C DUE TO (| PR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE OR AS A CONSE Institute of the consecution of t | reaulting 3 DOA 28b. TiM IN. 10me, farm, r Investigation | 26. P OTHER: 4 Nursing Hor IE OF 28c. IN JURY M 1 street, factory, offi | PLACE OF DEATH (Come 5 Residence JURY AT ORK? YES 2 NO ce te end plece, end du death occured at th | heck only one) 6 Other (S) 28d. DESCR 28f. LOCATH City or 1 | e. WAS AN AUPPERFORME YES 2 Pecify) IBE HOW INJU ON (Street and down, State) (e) and menne d place, and d | TOPSY ED? NO URY OCCURE Number or Ru or as stated. | 2 dl. 24b. WERE AUTOPSY FIN ANALABLE PRIOR T COMPLETION DF CL DF DEATH? 1 YES 2 N N Neel (e) end menner ee ste | IDINGS TO AUSE |

32. REGISTRAR'S SIGNATURE

| | | 1 | FOR STATE REGISTRAR 1. DECEDENT'S NAME (First, Middle, Last) | STATE OF MARYI | | DEPARTMENT RTIFICATE | | TH | REG. NO. | | 0 | 34410 |
|---|--------------------|-------|--|---|-------------------------|--|---|------------------|--|--------------|---------------|--|
| | E | | SOCIAL SECURITY NUMBER | ORCE M. | (In yrs. last t | LGHT | 1 YEAR IN INC. | * | DATE OF BIRTH | 26 9 | O . | TIME OF DEATH ZOAM CE (State or Foreign |
| 3 should | Ψ | 1 | 215-01-6678 90. FACILITY NAME (If not institution, give s | 1 M 2 D F | 53 | YRS. MONTHS | DAYS HOURS | MIN. | Moeth, Day, Year 0 | 47 | Country) | and |
| 2 | DIRECTOR | - | SINAL HOSPI RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | TAL | | B | | ORE | City | | | |
| permit. Pages 1, | AI DIR | - 11- | | Arundel | | Glen I | | DE | | 10a CITIZE | 10 | I. INSIDE CITY LIMITS? YES 2 X NO T COUNTRY? |
| in. ansit pe | FUNERA | | 408 Ferndale Rd. | | | | 210 | 061 | | U.S. | | COOKINT |
| 3-3146 ending physician. as the burial-transit | Ä | | 11. MARITAL STATUS 1 Never Merriad 2 🖔 Merriad 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 XNO | | WAS DECENDENT If yee, epecify Cu I TYES 2 X N | ban, Mexicen, Pu | RIGIN? (Specify Yee erto Rican, atc.) | or No— t4 | Specify: | American Indian, hite, etc. hite |
| 2120 ital or att d for use | OI ETED | - | 15. DECEDENT'B EDU- (Specify only highest grade Elementary/Secondery (0-12) | | (Give | EDENT'S USUAL Of the kind of work done to NOT use retired.) hanic | CCUPATION during most of wor | king | 18b. KIND OF BUS | | | |
| MARYLAND 2: retained by the hospital 5 should be detached fo | at once. | | 12 17. FATHER'S NAME (First, Middle, Lest) Samuel Knight | | Mec | nanic | | THER'S NAME (F | Transpor | | n | |
| MARY retained 5 should | TO By | | 19a. INFORMANT'S NAME (Type/Print) Barbara Kunkel | | | | | | Number, City or Town | | ode) | |
| RE, I | must be | ľ | 20e. METHOD OF DISPOSITION 1X Buriel 2 Cremetion 3 Rem | oval from State | b. PLACE Of other place | F OISPOSITION (No | me of cemetery, ca | ematory or | 20c. LOC | CATION — CIT | | |
| BALTIMORE, I rrs after death. Page 6 may be n by the funeral director, page removal. | examiner m | - 19- | 4 Donetion 5 Other (Specify) 21. BIONATURE OF FEMERAL SERVICE LIC | | len H | K | name and addi rkley H | uneral | Y Home | | | A.A., MD MD 21061 |
| S, within 24 nou pletely filled it cremation, or | event, the medical | | 23. PART i. Enter the diseases, or ahook, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | List only one cause on DUE TO (OR AS | aach lina. MDN | IA. | tha moda of o | lying, auch aa | cardiac or reapi | retory arrea | nt, | Approximate Interval Batwean Onsat and Death |
| O. BOX 13: certificate be execunding physician and Hygiene prior to bur | or other traumatic | | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | bDUE TO (OR AS cDUE TO (OR AS d | | • | | ¢ | | | | |
| ECORDS, equires that the den signed by the of Health and Me | hows any inju | | PART II. Other algolificant condition | ATELEC | | | ndarlyling cause | e given in Pari | 24e. WAS AN PERFOR | MED? | CO DF | RE AUTOPSY FINDINGS ALLABLE PRIDR TO MPLETION OF CAUSE DEATH? YES 2 NO |
| - 0 S e | item 2 | | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | tpatient 3 [| DOA 4 Nu | | Residence 8 | | | | |
| PHYSIC This ce | -00 | 127 | 27. MANNER OF DEATH Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? | 286 | I. DESCRIBE HOW II | NJURY OCCU | IRED | |
| TEN TOR | 80 H | | 3 Suicide 8 Could not be 4 Homicide determined | 28e, PLACE OF INJUR building, etc. (Sp | IY — At hom ecify) | ne, ferm, street, fac | tory, office | 281 | . LOCATION (Street a City or Town, State) | and Number o | r Aural Route | Number, |
| | = 5 | | one) | ER: On the beet of my kno | | | | | | | | nd menner ea stated. |
| TO THE HOSPITAL TO THE FUNERAL De filed within 72 | E H | | 296. SIGNATURE AND TITLE OF CERTIFIE | E. Nah | m | M.D | 29c. L | ICENSE NUMBER | | 29d. DATE ! | 1/2 | 6/90 |
| | | | E. NAHUM, M.D. | SINAL HOS | P | BELVED | ERE Q | GREEN | SPXING, | AVE | BAL | T. MD Z12 |
| | | | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | and le | | | | | | | |



3. TIME OF DEATH

10d. INSIDE CITY
LIMITS?

1 YES 2 NO

Approximata Interval Between

Onsat and Death 2 0045

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 | YES 2 | NO

and due to the cause(a) and manner as stated. 29d. DATE SIGNED (Month, Day, Year)

8. BIRTHPLACE (State or Foreign Country)

REG. NO.

2. DATE OF DEATH MONTH

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

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| | | 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In y | rs. last birthday) | IF UNDER | | IF UNDER 24 H | - // | ATE OF BIRTH Month, Day, Year) | | 8. BIRTI | HPLACE (State or Foreign |
|---|--|--|--------------------------|--|--|------------------------|----------------------------|------------|----------------------------|------------|---|-----------------------|-----------|--|
| No. | I | 215 05 9 | 303 | 1 M 2 □ F | 80 | YRS. | MONTHS | DAYS | HOURS | | vember 2 | 6'09 | | |
| B. B. | | 90. FACILITY NAME (If not in Howard Cour | | | spital | , | 9b. CITY, | | a LOCATION O | | | Howa | - | DEATH |
| 5 | | RESIDENCE OF DEC | | | | | | | | | | | | |
| it. Pages 1, 2, 2 | | Maryland | HOW | - | | | COLL | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| nsit perm | | 3717 Ligo | | | | | | 10f | 2104 | 3 | | | zen of | what country? |
| the burial-tra | | 11. MARITAL STATUS 1 Never Married 2 🔀 3 Wildowed 4 Divo | | 12. WAS DECEDE FORCES? IF YES, GIVE | NT EVER IN U.S 1 YES 2 WAR OR DATES | ON/EN | 11 | yes, sp | | exican, Pu | RIGIN? (Specify Year arto Rican, atc.) | | 14. RAC | E — American Indian, ck, White, atc. |
| se as | | | EOENT'S EOU | | 16 | a. DECEOENT'S | S USUAL OC | CUPATIO | ON et of working | | 18b. KIND OF BU | SINESS/INC | USTRY | |
| spital or a ned for us | | Elementary/Secondary (| 1 | College (1-4 or 5 | +) | life. Do NOT u | emp1c | | | | Prin | ting | Bus | iness |
| ed by the hospital uld be detached for ed at once. BE COMPL | | 17. FATHER'S NAME (First, M Marion S | | Sr. | | | | | | | irst, Middle, Meiden Maddox | Surname) | | |
| e retained to a should notified | - 10 | Mrs Margue | | ing | | 3717 | address Ligor | (Street a | ad E11 | icot | Number, City or Tow t City | n, State, Zip 2104 | | |
| e 6 may by ector, page must be | | 20a. METHOD OF DISPOSITION 1. The place of Disposition (Name of cameter), cramatory or other place) 20b. PLACE OF DISPOSITION (Name of cameter), cramatory or other place) 4 Donation 5 Other (Specify) 4 Donation 5 Other (Specify) | | | | | | | | | | | | |
| death. Page funeral din f. examiner | | ≥ Harr | | 1 | Pos | | Har | ry | | ke F | uneral H ia Pike | | | |
| executed within and completely fill, to burial, cremation, matic event, the ION | NOTICO IIII | shock, or it immediate CAUSE (Fidesese or condition resulting in death) Sequentially list condition and the cause. Enter UNDERLY CAUSE (Disease or injusted in that initiated events resulting in death) LAS | tiona, sidista ing | DUE TO SUPERIOR OF THE PROPERTY OF THE PROPERT | POPACA | PREFOL DISSEQUENCE OF | OFFICE OFFICE VIDEOU | | | E | | | | Interval Bet Onset and I |
| quires that the of a signed by the first health and Me lows any injury MFDICAL | The state of the s | PART II. Other signific | ant condition | ne contributing t | o dasth but | not reaulting | In the un | dariyin | g causa give | en in Part | 24a. WAS APPERFO | RMEP? | 24 | Ib. WERE AUTOPSY FINI AVAILABLE PRIOR TO COMPLETION OF CA OF DEATH? 1 YES 2 NO |
| V: The law re icate has bee State Dept. o Item 23 st | | 25. WAS CASE REFERRED 'EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHER | | LACE OF OEAT | H (Check o | nly one) | | | |
| sertificate the State of or Item | | 1 TES 2 NO | | 1 De Inpatient 2 | | | 4 🗆 Nurs | ing Hon | | ence 8 🗆 | Other (Specify) | | | |
| NG PHYSICIA fer this certi eath with the marked, or | | 27. MANNER OF DEATH 1 Natural 5 2 Accident | Pending Investigation | 28a. DATE C (Month, | Day, Year) | 28b. TI | ME OF IJURY M | WC | JURY AT ORK? YES 2 N | | I. DEŞCRIBE HOW | INJURY OC | CURED | |
| CTOR: After des 28 is n | s li | a Districted | Could not be determined | 28e. PLACE building | OF INJURY — g, etc. (Specify) | At home, farm | , street, fact | ory, offic | ca . | 281 | LOCATION (Street City or Town, State | and Numbe | r or Rumi | Route Number, |
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: TO THE FUNERAL DIRECTOR: After this certifica be filed within 72 hours after death with the St IMPORTANT: If Item 28 Is marked, or It O RF COMPLETED BY PHYSI | | contact only | | SICIAN: To the best ER: On the basis of | | | | | | | | | | (a) and manner as sta |
| FUNE Withir | - 11 | 29b. SIGNATURE AND TITL | | | | | | | 29c. LICENS | | | | | D (Month, Day, Year) |
| TO THE HDSPI TO THE FUNEF De filed within IMPORTANT: | | | | walls | | | | | | 7237 | | | | 25,1990 |

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Jack McWaters 11085 Little Patuxent Pkwy. Columbia Md.

32. REGISTRAR'S SIGNATURE

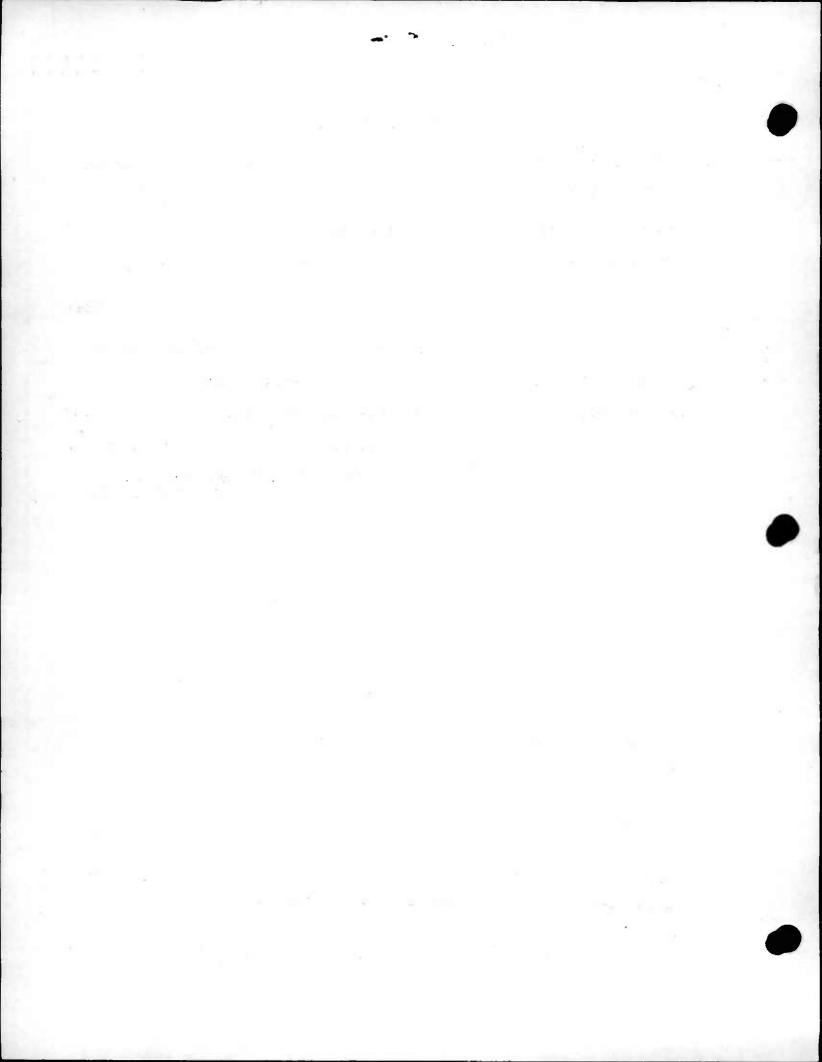
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH

ING Marion S. King Jr.

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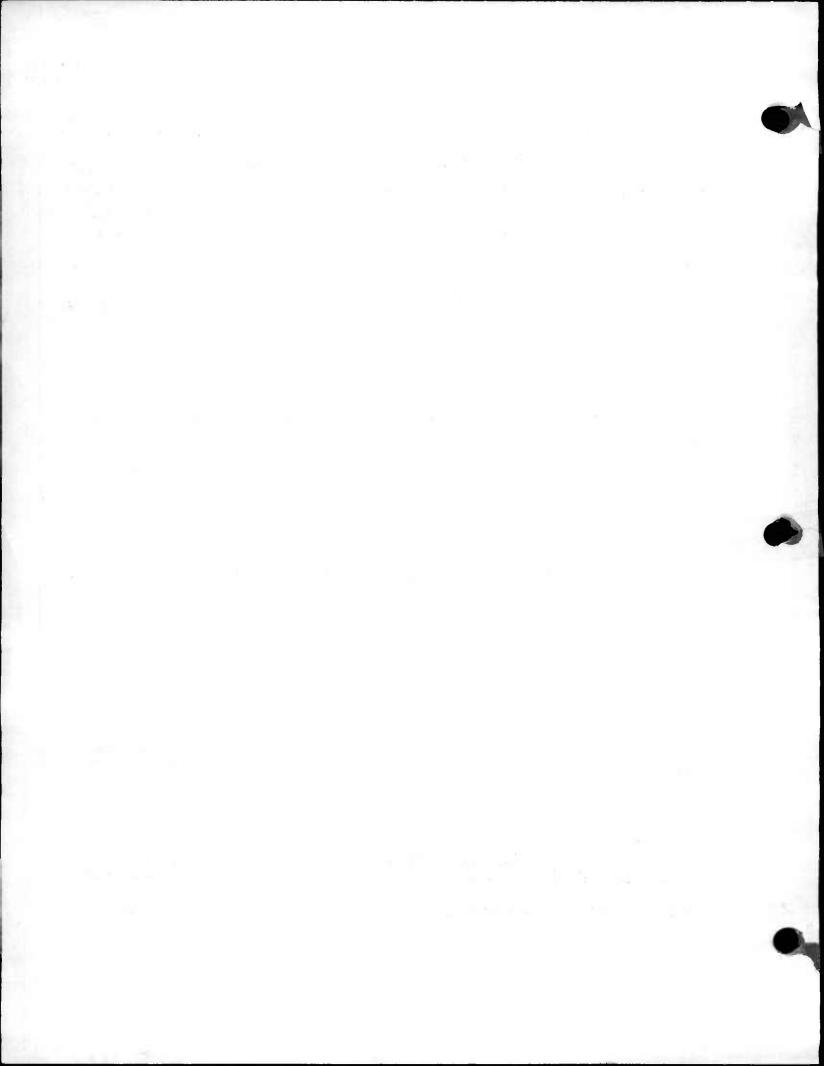
31. DATE FILED (Month, Day, Year)



Pages 1, 2, 3 should TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within the THE FUNERAL DIRECTIOR: After this certificate has been signed by the attention physician and completely. In by the funeral director, page 5 should be detached for use as the burial-train be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

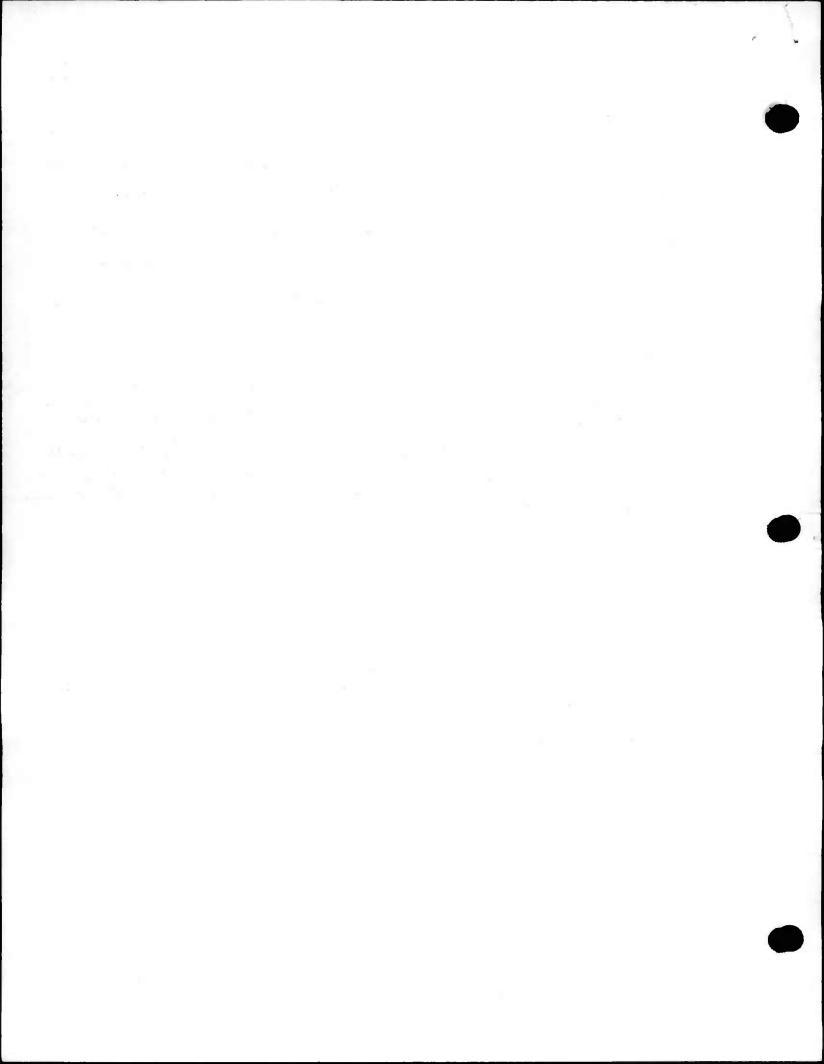
| | 1 - STATE CONTROL OF MAINTEAND / DEFARTMENT OF HEALTH AND MENIAL HYGIENE CERTIFICATE OF DEATH REG, NO. | | | | | | | | |
|---------------|--|--|--|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH MONTH DAY YEAR 3. TIME OF DEATH MONTH DAY YEAR | | | | | | | | |
| | 4. SOCIAL SECURITY NUMBER 5.77-18-0182A 1 M 2 VF 8 / VRS. 8. AGE (In yrs. lest birthday) F UNDER 1 YEAR F UNDER 24 NRS. 7. DATE OF BIRTH (Month, Days, Year) 8. BIRTHPLACE (State or Foreign Country) Country) Country) GEORGIA | | | | | | | | |
| TOR | 90. FACILITY NAME (If not institution, give street and number) Le I and Memorial Hospital Hyattsville Residence of decedent RESIDENCE OF DECEDENT 90. CITY, TOWN OR LOCATION OF DEATH HYATTSVILLE RESIDENCE OF DECEDENT | | | | | | | | |
| DIRECTOR | 106. STATE MD 10b. COUNTY Prince George Hyattsville 10d. INSIDE CITY LIMITS? 1 1 Yes 2 NO | | | | | | | | |
| FUNERAL | 101. STREET AND NUMBER 6646 23 4 9 78 2 109. CITIZEN OF WHAT COUNTRY? 20782 109. CITIZEN OF WHAT COUNTRY? U. S. A. | | | | | | | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Wildowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— lif yee, epecify, Cuben, Mexicen, Puerto Ricen, elc.) 14. RACE — American Indian, Black, White, etc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— lif yee, epecify, Cuben, Mexicen, Puerto Ricen, elc.) 16. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— lif yee, epecify, Cuben, Mexicen, Puerto Ricen, elc.) 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No— lif yee, epecify, Cuben, Mexicen, Puerto Ricen, elc.) | | | | | | | | |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use refited.) 18b. KIND OF BUSINESS/INDUSTRY PRIVATE HOMES | | | | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) HENRY JACKSON 18. MOTHER'S NAME (First, Middle, Malden Surname) ADDIE HARRIS | | | | | | | | |
| 10 | 196. INFORMANT'S NAME (Type/Print) 196. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 119 W. CENTENNIAL AVE, ROOSEVELT, N.Y. 11575 | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 1 W Burlel 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State 20c. LOCATION — City or Town, State | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY PEYTON FUNERAL HOME 2205 SHIRLINGTON ROAD ARLINGTON, VA 22206 | | | | | | | | |
| | 23. PART I. Enter the dieeeses, or complicetions that ceused the death. Do not enter the mode of dying, such as cardisc or respiratory arrest, shock, or heart failure. List only one ceuse on each line. IMMEDIATE CAUSE (Finel Approximate interval Between Onset and Death | | | | | | | | |
| N | disease or condition resulting in death) s. Myouandial Infanction minty Sequentially list conditions. Sequentially list conditions. Sequentially list conditions. | | | | | | | | |
| CERTIFICATION | If sny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disesse or injury | | | | | | | | |
| CERTI | resulting in desth) LAST | | | | | | | | |
| : MEDICAL | PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO 24b. WERE AUTOPSY FINDINGS ANALIABLE PRIDE TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | |
| PHYSICIAN: ME | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: OTHER: | | | | | | | | |
| BY PHYS | 1 Inpatient 2 Fr/Outpetient 3 DOA 4 Nursing Home 5 Recidence 8 Other (Specify) 27. MANNER OF DEATH 1 Shatural 5 Pending 28e. DATE OF INJURY (Month, Dey, Year) Pending 28e. DATE OF INJURY 28e. INJURY AT WORK? 2 Accident Investigation Work? 1 YES 2 NO | | | | | | | | |
| | 3 Suicide 4 Homicide 8 Could not be determined 8 Could not be determined 2se. PLACE OF INJURY — At home, ferm, atreet, factory, office building, etc. (Specify) 2se. PLACE OF INJURY — At home, ferm, atreet, factory, office City or Town, State) | | | | | | | | |
| COMPLETED | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To like best of my knowledge, death occurred at the lime, date end place, end due to like cause(e) end menner ee stated. 2 MEDICAL EXAMINER: On the basic of examination end/or investigation, in my opinion, death occurred at the time, date end place, end due to like cause(e) end menner ee stated. | | | | | | | | |
| TO BE C | 290 SIGNATURE AND TITLE OF CERTIFIER DATE PLONES AND THE PLONES AN | | | | | | | | |
| | Pullander Examiner DO1852 > 11-21-90 30. MAME AND ADDRESS OF PERSON MHO COMPLETED CAUSE OF DEATH (ITEM 27) (Typo, Print) PAVI A. DEVORE MD 4203 QUEENS bury Rel Hyattsville M.D 2028; | | | | | | | | |
| | 31. DATE FILED (Month, Day, Year) Solve Service Sunature Suna Davidson Rendelle | | | | | | | | |



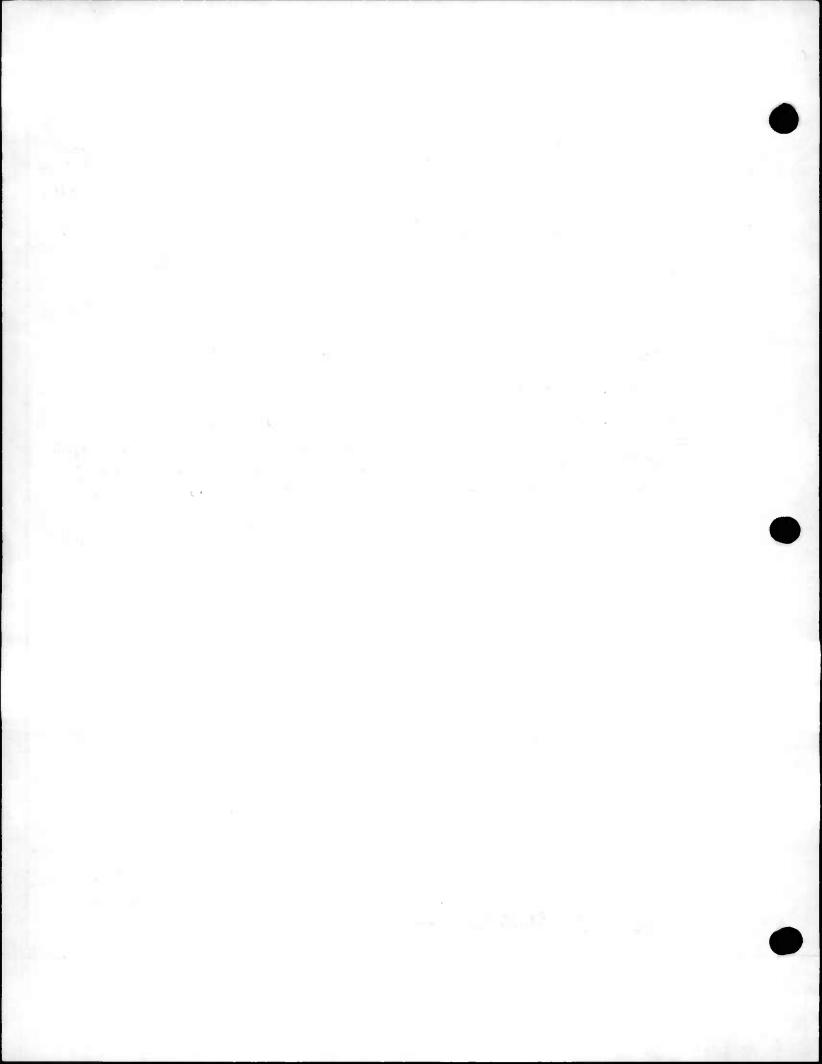
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | | |
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| OF VITAL RECORDS, P.O. | 13146, | |
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| | DIVISION | |

31. DATE FILED (Month, Day, Year) 90

| | | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | | T OF HEALTH AND | MENTAL HYGIENS REG. NO. | | 04115 |
|--|-----------------|---|--|--|--|---|-------------------------------|---|
| ſ | į | 1. DECEDENT'S NAME (First, Middle, Last) HOWAR | D W. | KLAI | RE | 2. DATE OF DEATH DAY | + 9 YEAR | 3. TIME OF GEATH 5. OOP, M |
| | ! | 4. SOCIAL SECURITY NUMBER 214-24-8667 | 1 🗆 M 2 🗆 F | yrs. lest birthday) IF UND YRS. MONTH | ER 1 YEAR IF UNDER 24 HRS. DAYE HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT | HPLACE (State or Foreign tity) Auglavelau |
| | TOR | 90. FACILITY NAME (If not institution, give str Carroll Co. RESIDENCE OF DECEDENT | Gen, Hosp | pital W | lestmins | tes- | 9c. COUNTY OF | CO / |
| | DIRECTOR | 10a, STATE 10b, COUNTY | rvo [/ | 10c. CITY, TOWN | OR LOCATION AMPSTEAD | 1 | | 10d. INSIDE CITY LIMITS? 1 La YES 2 NO |
| | FUNERAL | 100. STREET AND NUMBER | h MAIL S | st. | 101. ZIP CODE Z/0 | 74 | 10g. CITIZEN OF | WHAT COUNTRY? |
| | à | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Olvorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 (JNO | N. WAS DECENDENT OF HISPA If yes, specify Cuben, Mexic 1 YES 2 NO Speci | en, Puerto Rican, atc.) | Bla | CE — American Indian, ck, White, atc. |
| | PLETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondery (0-12) | | 18e. DECEDENT'S USUAL (Give kind of work don life. Do NOT use retired SA/ES/V | e during most of working .) | 186. KIND OF BUS | WAVE | _ |
| at once. | BE COMPL | 17. FATHER'S NAME (First, Middle, Last) HAVVY | B KLAV | , | | AME (First, Middle, Malden Sh | Sumeme) OWAKE | · · |
| | TO B | 190. INFORMANT'S NAME (TypePrint) | KLAVE | 19b. MAILING ADDRE | ss (Street and Number or Rural South MAI) | Route Number, City or Town | n, State, Zio Code) PSTEAO | 1, Md. |
| must | 1 | 20e. METHOD OF DISPOSITION 1 Suriel 2 Cremellon 3 Remo 4 Donation 5 Other (Specify) | 20b. | PLACE OF DISPOSITION (other place) The place of the pla | Name of cemetery, cremetory or | 14 | . 1 | Town, State |
| or removal. | | 21. SIGNATURE OF FUNERAL SETWICE LIC | he and | 2 | 2. NAME AND ADDRESS OF F. Eckhault 3296 Cha | Funera | Manche | pe (ZIIOZ |
| | | 23. PART I. Enter the diseases, or c shock, or heart failure. I IMMEDIATE CAUSE (Final disease or condition resulting in death) | Liet only one cause on ea | the death. Do not ent ch line. CONSEQUENCE OF): | | | | Approximate Interval Between Onset and Death |
| to burial, | NOI | Sequantially list conditions, if any, leading to immediate | OUE TO (OR AS A | CONSEQUENCE OF): | | | | |
| and Mental Hygiene prior to burial, cremation, y injury, or other traumatic event, the | RTIFICATION | cause, Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A | CONSEQUENCE OF): | | | | |
| Dept. of Health | AN: MEDICAL CEI | PART II. Other algnishment condition (RL) OCC 25. WAS CASE REFERRED TO MEDICAL | contribution to down but Cipy all (| it not reputting in the | anderlying cause given in the state of the s | PERFOR | MED? | ND. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| or item | YSICIAN: | 1 YES 2 XNO | HOSPITAL: | | ER: ursing Home 5 - Reeldence | 8 Other (Specify) | 7 | |
| marked, | ВУ РНУ | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 YES 2 NO | 28d. OEŞCRIBE HOW II | NJURY OCCURED | |
| n 28 is | ETED | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Speci | — At home, ferm, atreet, f | actory, office | 281. LOCATION (Street a City or Town, State) | and Number or Rure | il Route Number, |
| 2 = | COMPL | enel | CIAN: To the best of my knowle R: On the beste of examination | | | | | e(e) end menner ee stated. |
| be filed within | 8 | 29b. SIGNATURE AND TITLE OF CERTIFIER | lang | MO | 29c. LICENSE NI | O 15 | ≥ (Z | ED (Month, Day, Year) 4 90 |
| 2 € | 0 | 30. NAME AND ADDRESS OF PERSON WHO | | | | | | |



| | REGISTRAR | | CERTIFIC | ATE OF | DEATH | | REG. NO | | | |
|-----------------------------------|---|---|--|-----------------------------|---|---------------------|-----------------------------------|---|---------------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | CING | | | | 2. DATE | OF DEATH | | 3. | TIME OF DEATH |
| 1 | 243-10-1643 | 1 🗆 M 2 🗡 F | - | FUNDER 1 YEAR INTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | | OF BIRTH | 10 | BIRTHPLA Country) | CE (State or Foreign North olina |
| DIRECTOR | 90. FACILITY NAME (If not institution, give street ANNE AVUNCE M RESIDENCE OF DECEDENT | edical Ce | nter Ä | nna | DOLIS | EATH | | Ann | | н |
| | | Anunde | Ma | MD OR LOCA | TION | | | | | I. INSIDE CITY LIMITS? YES 2 X NO |
| FUNERAL | 106. STREET AND NUMBER 11. MARITAL STATUS | r. Po Box | 237 | | 2110 | 6 | | US | N OF WHAT | COUNTRY? |
| ĕ | 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN U FORCES? 1 TYPES IF YES, GIVE WAR OR DATE | 2 XINO | If yes, s | CENDENT OF HISPA Hecity Cuben, Mexic 2 NO Speci | an, Puarto I | I? (Specify Yea Rican, atc.) | or No 14 | RACE — Black, Wi Specify: | American Indian, hite, atc. |
| LETED | 15. DECEDENT'S EDUCAT (Specify only highest grade coll Elementery/Secondary (0-12) | TION 1 mpleted) College (1-4 or 5+) | 18a. DECEDENT'S USO (Give kind of work life. Do NOT use re | done during m | ON ost of working | 16b | KIND OF BUS | SINESS/INDUS | TRY | |
| at once. | 17. FATHER'S NAME (First, Middle, Last) | | Photog | raphe | 18. MOTHER'S NA | | Free Middle, Malden | | | |
| # III | Walter B. Ander | son | | | Ora S | | | | | |
| TO TO | Arthur E. King | | 1659 | Cliff | nnd Number or Rural Drive | | | | | |
| must t | 20s. METHOD OF DISPOSITION 1 X Burlel 2 Cremation 3 Remova 4 Donation 5 Other (Specify) | I from State | PLACE OF DISPOSITION (Chither place) | ON (Name of ce | metery, crematory or | | 20c. LO | CATION - City | or Town, | State Lle,MD |
| medical examiner must be notified | 21. BIGNAPHE OF UNIVERSITY SERVICE LICEN | Laylor | / | Tayl | or Fune | eral | Chap | el | 2 | 1401 |
| event, the medic | 23. PART I. Enter the diseases, or con ahock, or heart fellure. Lis iMMEDIATE CAUSE (Final disease or condition resulting in death) | it only one cause on eac | t cell (| | | , | | ratory arrea | 9 | Approximate interval Between Onset and Death |
| | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CO | ONSEQUENCE OF); | | | | | | | |
| or other | CAUSE (Disease or Injury that initiated events resulting in death) LAST | DUE TO (OR AS A CO | ONSEQUENCE OF): | | | | | | | |
| A A | PART II. Other algnificant conditions of | ontributing to death but | not resulting in th | ne underlyln | g cause given in | Part I. | 24a. WAS AN | | | RE AUTOPSY FINDINGS |
| Me | | | | | | _ | 1 TES 2 | 1/ | OF I | IPLETION OF CAUSE DEATH? YES 2 NO |
| Item 23 | 25. WAS CASE REFERRED TO MEDICAL | | | 28 PI | ACE OF DEATH (Ch | | -1 | | | |
| ed, or item 23 s PHYSICIAN: | | OSPITAL: | | HER: | e 5 Residence | | | | | |
| marked, c | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 26b. TIME OF INJURY | 28c. INJ | URY AT RK? | | CRIBE HOW IN | JURY OCCUR | ED | |
| 28 Is TED | 3 Suicide & Could not be 4 Homicide determined | 28e. PLACE OF INJURY — building, etc. (Specify) | At home, farm, street | t, factory, offic | | 28f. LOCA City o | TION (Street as r Town, State) | nd Number or I | Rural Route | Number, |
| AP AP | 29e. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAL CONTROL EXAMINER: 0 | N: To the best of my knowledge On the basis of examination ar | ge, death occurred at | the time, date | and place, and dua | time, data | ee(a) and man | ner se stated. | suse(s) and | manner as stated. |
| TO BE COM | 296. SIGNATURE AND TITLE OF CERTIFIER | ouil uo | | | 29c. LICENSE NUN | | | 29d. DATE SI | | |
| F | STUBULE - SEL | OMPLETED CAUSE OF DEATH | (ITEM 27) (Type, Print | Vasal | lin St. | Au | happel | is un | | 1401 |
| | 31. DATEDECOO 7. 1990 3 | lite observation with | physics . | VUCUU | ALVE OIL | - 1 | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | |



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| OF VITAL RECORDS | |
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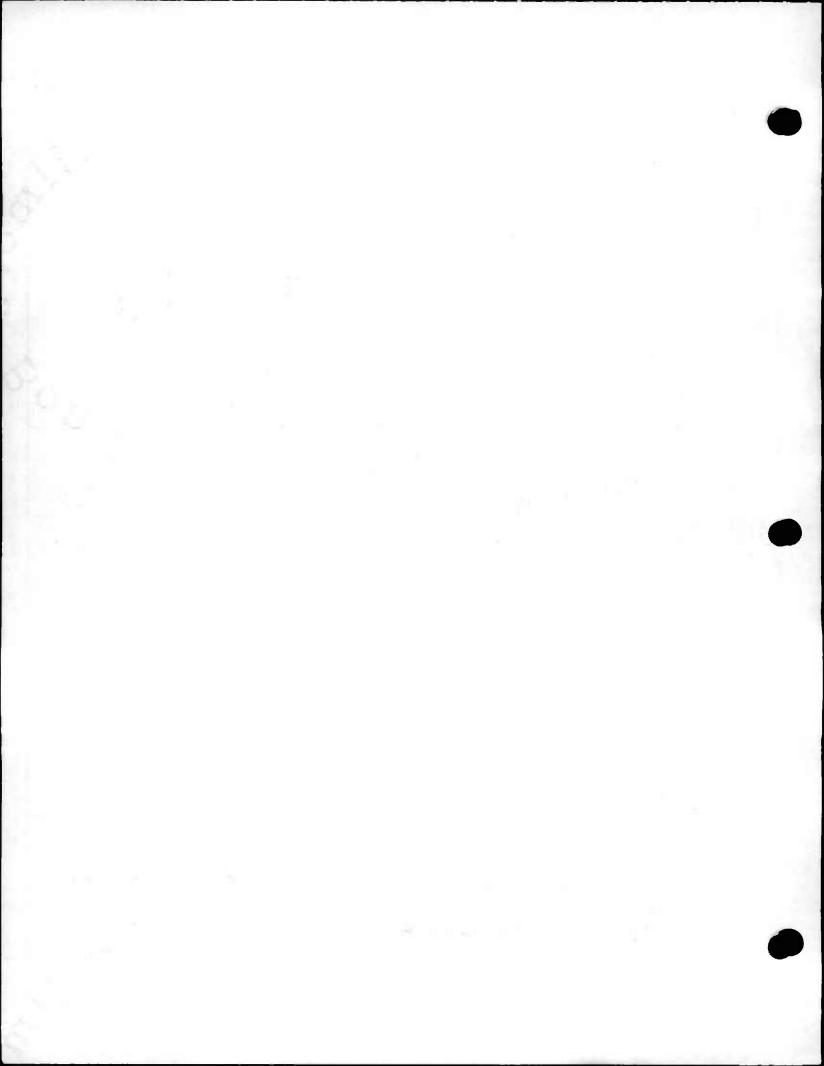
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit to | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlat, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| TO THE H | TO THE FI | be filed w | IMPORT/ |

| | FOR STATE REGISTRAR | STATE OF MA | RYLAND / DEPAI CERTIF | RTMENT OF H | EALTH AND I | MENTAL HYGIEN | E . | 90 34421 |
|--------------------|--|---------------------------------|---|---|----------------------|--|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | 1.2 cm | merma | N | | 2. DATE OF DEATH | y year | |
| | 4. SOCIAL SECURITY NUMBER | | AGE (in yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 6. BII | RTHPLACE (State or Foreign |
| | 219-30-2303 | 1 🗆 M 2 💢 F | QU YRS. | MONTHS DAYS | NOURS MIN. | (Month, Day, Year) | | irginia |
| | 9a, FACILITY NAME (if not institution, give str | reet and number) | , , | 9b. CITY, TOWN | OR LOCATION OF DE | ATH | 9c. COUNTY O | |
| 5 | Anne Arundel M | sedical (| Center | Anna | apolis | | Anne | Arundel |
| 3 | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c, Cr | TY, TOWN OR LOCAL | TION | | | 10d. INSIDE CITY |
| Ē | Maryland Anne | Arunde | 1 | Annapo! | lis | | | LIMITS? 1 X YES 2 NO |
| ارَ | 10e. STREET AND NUMBER | , | | | . ZIP CODE | | 10g. CITIZEN C | OF WHAT COUNTRY? |
| | 1404 West Str | reet | | | 21401 | | U.S. | Α. |
| FUNERAL DIRECTOR | 11. MARITAL STATUS | 12. WAS DECEDENT E | | | ENDENT OF HISPAN | NIC ORIGIN? (Specify Yes | or No- 14. R | ACE — American Indien, Back, White, etc. |
| | 1 Never Merried 2 Merried | FORCES? 1 | | | 2 NO Specific | n, Puerto Rican, etc.) y: | s | pecify: |
| | 3 Widowed 4 Divorced | | | | | | | hite |
| COMPLEIED | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | 16e. DECEDENT' (Give kind of | S USUAL OCCUPATION work done during me | ON ost of working | 16b. KIND OF BUS | SINESS/INDUSTR | Y |
| ן ב | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | 7.7 | | |
| ξ | 17. FATHER'S NAME (First, Middle, Lest) | | Hon | nemaker | 18 MOTHER'S NA | ME (First, Middle, Maiden | Sumama | |
| | Charles Havdo | | | | | | Comano | |
| | 19e. INFORMANT'S NAME (Type/Print) |) [[| 19b. MAILIN | G ADDRESS (Street | | George Route Number, City or Tow | n, State, Zip Code |) |
| 2 | Dorothy Freema | n | 2777 | Glanc | rost Ci | rcle Any | iloge | s.MD 21401 |
| 1 | 20e. METHOD OF DISPOSITION | | 20b. PLACE OF DISP | | | | CATION — City of | |
| | 1 XBurlet 2 Cremetion 3 Remo | oval from Stete | ther place) | mcoln (| Cemeter | v Br | entwoo | d. MD |
| | 1, SIGNATURE OF FUNERAL BERVICE LIC | ENSEE | 011 | 22. NAME A | ND ADDRESS OF FA | CILITY | | |
| | totarallal of | X . Z. | . 4u | | | ral Chap | | 21401 |
| | 23 PART i. Enter the diseases, or o | omplications that of | auaad the death. Do | | | ter St. | | Approximata |
| 1 | shock, or heart failure. | | | | 0.00 | | | Intarval Bstween Onset and Death |
| | IMMEDIATE CAUSE (Finsi disessa or condition | PNEU | MONIA | | | | | 5 DAYS |
| ł | reaulting in daath) | DUE TO (O | OR AS A CONSEQUENCE | OF): | | | | 20110 |
| z | | . JEVE | RE DE | MENTI | 7 | | | 10 YRS |
| 2 | Sequantisity flat conditions, if any, lasding to immediate | | R AS A CONSEQUENCE | | | | | |
| 2 | cause, Entar UNDERLYING CAUSE (Disease or injury | c | | | | | | |
| = | that initiated eventa | DUE TO (O | PR AS A CONSEQUENCE | OF): | | | | i |
| CERTIFICATION | Tooling in county and | d | | | | | | i |
| | PART ii. Other significant condition | a contributing to d | aath but not resulting | g in the underlyin | ig csuse given in | Part I. 24a, WAS AN | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| 2 | | | | | | 1 _ YES | | COMPLETION OF CAUSE OF DEATH? |
| 副 | | | | | | | | 1 YES 2 NO |
| z | | | | | | | | |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSBITAL | | _ | LACE OF DEATH (C | heck only one) | | |
| | 1 TES 2 NO | HOSPITAL: | ER/Outpetlent 3 DOA | OTHER: 4 Nursing Ho | me 5 🗆 Reeldence | 8 Cher (Specify) | | |
| H | 27. MANNER OF DEATH | 28e. DATE OF IN (Month, Day, | YJURY 28b. T | IME OF 28c. IN NJURY W | JURY AT ORK? | 28d. DEŞCRIBE HOW | INJURY OCCURE | D |
| B | 1 Natural 5 Pending 2 Accident Investigation | | | | YES 2 NO | | | |
| | 3 Suicide 6 Could not be | 26e. PLACE OF building, et | INJURY — At home, farm ic. (Specify) | s, street, fectory, offi | ce | 281. LOCATION (Street City or Town, State | | ural Floute Number, |
| | | | | | | | | |
| COMPLETED | (Crieck only | | ny knowledge, death occu | | | | | |
| ğΪ | 2 MEDICAL EXAMINE | R: On the beele of exa | mination end/or investiga | tion, in my opinion, | death occured et the | e time, date end place, e | nd due to the ce | uss(e) end menner ee stated. |
| 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | At Ed | m MD | | 29c, LICENSE NU | 701 | ≥ /2 | ANED (Month, Day, Year) |
| 임 | 30. NAME AND ADDRESS OF PERSON WH | O COMPLETED CAUSE | | pe, Print) RDŒL | V Mill | ANNAPOLIS, | MI) 2 | 1411 |
| | 31. DATE FILED (Month, Day, Year) | - I-32. REGISTRAR | | MARCEL | MUE | TINALOUS, | | 101 |
| | | | Devidson-Rand | .00 | - | | | |
| | DEC 0.7.1 | Jyl gima | mulacon-Mayla | apris | | | | DHMH-16 Rev 1/89 |

. . .

| BALTIMORE, MARYLAND 21203-3146 | • nours after death. Page 6 may be retained by the hospital or attending physician lifed in by the funeral director, page 5 should be detached for use as the burial-transmit in, or removal. • medical examiner must be notified at once. |
|--|---|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within any viors after death. Page 6 may be retained by the hospital or attending physician, TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit public filled within TD hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician. |

| | FOR STATE REGISTRAR | STATE OF MARYL | AND / DI | EPARTMENT RTIFICATE | OF D | LIH AND M EATH | | EG. NO. | : | |
|---------------------------------|--|--|--|---|--|--|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | DEATH DAY | YEA | 3. TIME OF DEATH |
| | Yo Mun Kim | | | | | | Dec. | | 1990 | 3:00 A.M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX B. AGE | (In yrs. last bir | | | UNDER 24 HRS. | 7. DATE OF E | BIRTH N. Year) | | IRTHPLACE (State or Foreign ountry) |
| | 217-98-3441 | 1 ☑ M 2 □ F 5 | 4 | YRS. MONTHS | DAYS HO | OURS MIN. | Dec. | | | outh Korea |
| | 9a. FACILITY NAME (If not institution, give s | treet and number) | | 9b. CITY, | TOWN OR L | OCATION OF OE | ТН | | 9c. COUNTY (| OF DEATH |
| OR | 6455 Colonial Ci | rcle | | Gle | n Bur | nie | | | Anne A | Arundel |
| ᇈ | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | Y | - 1 | 10c. CITY, TOWN O | R LOCATION | | | | | 10d. INSIDE CITY |
| E | | Arunde1 | | Glen Bu | rnie | | | | | 1 YES 2 NO |
| 1 | 10a. STREET AND NUMBER | ni diidei | | oren be | _ | P CODE | | | 10g. CITIZEN | OF WHAT COUNTRY? |
| BY FUNERAL DIRECTOR | 6455 Colonial Dr | ive | | | 21 | 061 | | | U.S.A. | |
| S | 11. MARITAL STATUS | 12. WAS DECEDENT EVER | IN U.S. ARME | | WAS DECEN | DENT OF HISPAN | C ORIGIN? (S | Specify Yes | or No- 14. | RACE — American Indian, Black, White, atc. |
| 7 | 1 Never Married 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR | | | | NO Specify: | | ,, | | Specify: |
| | 15. DECEDENT'S EDU | I CATION | Ten Dece | DENT'S USUAL O | CHIBATION | | 16h KII | ND OF BUS | I SINESS/INDUST | Oriental |
| 里 | (Specify only highest grade | e completed) | (Give | kind of work done on NOT use retired.) | during most o | of working | 1000.10 | | | |
| 2 | Elamentary/Secondary (0-12) | Collega (1-4 or 5+) | GLOVE | e Maker | | | In | dust | ria1 | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | - | 10101 | CHARCE | - 1 | 8. MOTHER'S NAI | | | | |
| | Hak Yong Kim | | | | | Su Hyor | n Kang | | | |
|) BE | 19a. INFORMANT'S NAME (Type/Print) | | 196. [| MAILING ADDRESS | S (Street and | Number or Rural F | loute Number, | City or Town | n, State, Zip Coo | ie) |
| 2 | Yong Wook Kim | | 62 | 0 Paddle | Whe: | ll Ct., | Mille | | | 21108 |
| | 20a. METHOD OF DISPOSITION 1 X Burial 2 Cremation 3 Ran | noval from Stata | other place | | | | | | CATION — City | |
| 1 | 4 Donation 5 Other (Specify) | | Meadow | ridge M | | al Park | | Dor | sey, H | oward, MD |
| | 21. SIGNATURE OF FUNERAL SERVICE L | CENSEE | Λ | | | Funera | | ie. | | |
| | Twent 1 | mon The | hr | | | | | | | nie, MD 21061 |
| 100 | 23. PART I. Enter the diseases, or | complicatione that cause | ed the deat | th. Do not enter | the mode | of dulpa aud | h as cardle | c or reep | ratory erreet | Approximete |
| 1 9 | III ehock, or haart tallure. | . List only one cause on | eech line. | | the mode | or dying, suc | ii ee ceidie | | • | interval Batwaan |
| | IMMEDIATE CAUSE (Final | . List only one cause on | eech line. | | the mode | or dying, such | il ee cerdie | | , | Interval Batwaan Oneat and Deeth |
| | Market Control House Control | a Depat | eech line. | a | the mode | or dying, suc | T ee Cerdie | | | interval Batwaan |
| | IMMEDIATE CAUSE (Final disease or condition | a. Due to (on As | eech line. | a | THE HIGGS | or dying, such | ii ee coldie | | | interval Batwaan |
| NO | iMMEDIATE CAUSE (Final disease or condition reauting in death) | a Depat | OVV. | JENCE OF): | THE HIGH | y or dying, suc | i ee coldie | | | interval Batwaan |
| ATION | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | a. DUE TO (OR AS | OVV. | JENCE OF): | THE THOUSE | y or uyang, suc | The Coldie | | | interval Batwaan |
| IFICATION | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. DUE TO (OR AS | S A CONSEQUE | JENCE OF): | | or dynig, suc | The Coldinate | | | interval Batwaan |
| ERTIFICATION | iMMEDIATE CAUSE (Final disease or condition reauting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a. DUE TO (OR AS | S A CONSEQUE | JENCE OF): | | or dynig, suc | The Coldie | | | interval Batwaan |
| CERTIFICATION | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. DUE TO (OR AS D. DUE TO (OR AS C. DUE TO (OR AS | S A CONSEQUENT OF S A CONSEQUE | JENCE OF): JENCE OF): | | | | 24s, WAS AN | N AUTOPSY | Oneat and Deeth Concern of the Conc |
| N N | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS D. DUE TO (OR AS C. DUE TO (OR AS | S A CONSEQUENT OF S A CONSEQUE | JENCE OF): JENCE OF): | | | Part I. 2 | 4a. WAS AND PERFO | N AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| N N | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS D. DUE TO (OR AS C. DUE TO (OR AS | S A CONSEQUENT OF S A CONSEQUE | JENCE OF): JENCE OF): | | | Part I. 2 | 24s, WAS AN | N AUTOPSY RMED? | Oneat and Deeth Compared to the Compared to |
| MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS D. DUE TO (OR AS C. DUE TO (OR AS | S A CONSEQUENT OF SA CONSEQUENTS A CONSEQUENT OF SA CONSEQUENTS OF | JENCE OF): JENCE OF): | | | Part I. 2 | 4a. WAS AND PERFO | N AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. | a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. Does contributing to daeth | S A CONSEQUENT OF SA CONSEQUENTS A CONSEQUENT OF SA CONSEQUENTS OF | JENCE OF): JENCE OF): JENCE OF): JENCE OF): | nderlying 28. PLA | | Part I. 2 | 44. WAS AN PERFOI 1 YES : | N AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO (OR AS D. DUE TO (OR AS C. DUE TO (OR AS | s A CONSEQUENT DUTY TO THE PROPERTY OF THE PRO | JENCE OF): JENCE OF): JENCE OF): JENCE OF): | nderlying | cause given in | Part I. 2 | 24a. WAS AN PERFOI I □ YES : | N AUTOPSY RMED? 2 ∰ NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | a. DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DOE TO (OR AS HOSPITAL: | s A CONSEQUENT OF THE PROPERTY | JENCE OF): JENCE OF): JENCE OF): JENCE OF): | 28. PLA | CE OF DEATH (C) 5X Rasidence RY AT | Part I. 2 | 24a. WAS AN PERFOI I □ YES : | N AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 💆 NO | a. DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DOS contributing to dasth HOSPITAL: 1 Inpatient 2 ER/O 28a DATE OF INJUR (Month, Day, Yea | s A CONSEQUENT NOT TO BUT HOLD | JENCE OF): JENCE | 28. PLA R: raing Home 28c. INJU WOR 1 YE | CE OF DEATH (CE SX) Residence | Part I. 2 neck only one) 6 Other (28d. DESC | (Specify) | N AUTOPSY RMED? 2 2 NO | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reauiting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and investigations are conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigations and suicide 8 Could not be | a. DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS d. Due TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS DUE TO (OR AS | s A CONSEQUENT S A CONSEQUENT Dut not ra | JENCE OF): JENCE | 28. PLA R: raing Home 28c. INJU WOR 1 YE | CE OF DEATH (C) 5X Rasidence RY AT | Part I. 2 heck only one) 6 Other (28d. DESC | (Specify) | N AUTOPSY RIMED? 2 2 NO INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentieily ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the cause of the conditions of the cause | a. DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS | s A CONSEQUENT S A CONSEQUENT But not ra | JENCE OF): JENCE | 28. PLA FR: Irsing Home 28c, WJU 1 Yi ctory, office | CE OF DEATH (CI | Part I. 2 neck only one) 6 Other (28d. DESC 28f. LOCAT | 24a. WAS AN PERFOI YES : | N AUTOPSY RMED? 2 2 NO INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentieily ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are suiting in death) LAST PART II. Other algnificant conditions in the cause of the conditions are suiting in death) LAST PART II. Other algnificant conditions in the cause of the cause | a. DUE TO (OR AS DU | s A CONSEQUENT S A CONSEQUENT But not ra | JENCE OF): JENCE | 28. PLA FR: FR: Irsing Home 28c. INJU 1 YE ctory, office | CE OF DEATH (CI 5X Rasidence RX7 ES 2 NO | Part I. 2 neck only one) 6 Other (28d. DESC 28f. LOCAT City or | (Specify) RIBE HOW | N AUTOPSY RMED? 2 2 NO INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the examiner of the exa | a. DUE TO (OR AS DU | s A CONSEQUENT S A CONSEQUENT But not ra | JENCE OF): JENCE | 28. PLA FR: FR: Irsing Home 28c. INJU 1 YE ctory, office | Cause given in CE OF DEATH (CI 5-X Rasidence RY AT IK? ES 2 NO and place, and du ath occured at the | Part I. 2 heck only one) 6 Other (28d. DESC 28f. LOCAT City or a to the cause time, data a | (Specify) RIBE HOW | N AUTOPSY RMED? 2 ② NO INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(a) and menner as stated. |
| COMPLETED BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentieily ilst conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions are suiting in death) LAST PART II. Other algnificant conditions in the cause of the conditions are suiting in death) LAST PART II. Other algnificant conditions in the cause of the cause | a. DUE TO (OR AS DU | s A CONSEQUENT S A CONSEQUENT But not ra | JENCE OF): JENCE | 28. PLA FR: Irsing Home 28c. INJO 1 YE ctory, office | CE OF DEATH (CI 5X Residence RY AT IK? ES 2 NO and place, and du ath occured at the | Part I. 2 heck only one) 6 Other (28d. DESC 28f. LOCAT City or a to the cause time, data a | (Specify) RIBE HOW FION (Street Town, Steleten) and middle and place, a | INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(a) and menner as stated. |
| BY PHYSICIAN: MEDICAL | iMMEDIATE CAUSE (Final disease or condition reaulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions and the examiner of the exa | a. DUE TO (OR AS b. DUE TO (OR AS c. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS d. DUE TO (OR AS DUE | s A CONSEQUENT S A CO | JENCE OF): JENCE | 28. PLA FR: Irsing Home 28c. INJO 1 YE ctory, office | CE OF DEATH (CI 5X Residence RY AT IK? ES 2 NO and place, and du ath occured at the | Part I. 2 heck only one) 6 Other (28d. DESC 28f. LOCAT City or a to the cause time, data a | (Specify) RIBE HOW FION (Street Town, Steleten) and middle and place, a | INJURY OCCUI | 24b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO RED Rural Route Number, cause(a) and menner as stated. |



| | mit. Pages 1, 2, 3 should |
|--|--|
| BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the hospital or attending physician. TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and complete the property of the physician and complete the physician and of the physician and Menial Hygiene prior to burial, creminden, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| | illed in mon, or n the med |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed with the formation of the transportation of the complete state of the transportation and complete state that the fundamental properties after death with the State Dept. of Health and Mental Phylene prior to burial, creminating, or removal. IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examples as the control of the cont |
| P.O. B | ath certifica tending ph at Hyglene or other |
| ECORDS, F | quires that the dean signed by the at if Health and Mentions any Injury, |
| TAL RI | ate has bee tate Dept. o |
| OF VI | PHYSICIAN this certific with the S rked, or I |
| SION | TTENDING TOR: After after death 28 is ma |
| DIV | PITAL OR A FRAL DIREC 172 hours 1: 11 item |
| | TO THE HOSI TO THE FUNE be filed within |

| 1 - STATE REGISTRAR | | SIAIE UF I | MARYLAND / | ERTIF | CATE | OF | DEATH | NIEW IA | REG. NO. | | | 34423 |
|--|----------------------------------|--|--|----------------------------|---------------------|----------------|---|------------|---------------------------------------|--------------------|---|---|
| 1. DECEDENT'S NAME (First, | | lizaheti | 7 | | L | YN | CH | MONTI | OF DEATH DAY | | EAR 90 | . TIME OF DEATH |
| 4. SOCIAL SECURITY NUMB 184-22-3 | | Lizabet/ 5. SEX 1 □ M 2 XiF | 6. AGE (In yrs. let | st birthday) YRS. | IF UNDER 1 | YEAR DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE | OF BIRTH | 6. | BIRTHPI Country) | ACE (State or Foreign |
| 9e. FACILITY NAME (If not interpreted in PENINSULA G | ENERAL | | AL | | | | BURY, M | | | 9c. COUNTY WICO | | |
| 10a. STATE | | | | | | | ON | | | | IOd. INSIDE CITY LIMITS? I YES 2 NO | |
| 100. STREET AND NUMBER 48 Brand | | | | | | 101. | ZIP CODE | 811 | | 10g. CITIZE | N OF WI | AT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 | / | | | | H | yes, spe | ENDENT OF HISPAI city Cuban, Mexica 2 DYNO Specif | en, Puerto | N? (Specify Yee Rican, atc.) | or No — 14 | Black, Specify | - American Indian, White, etc. |
| 15. OEC (Specify onl Elemantary/Secondery (C | EDENT'S EDUC highest grade of | ATION completed) College (1-4 or 5 | S | Give kind of the Do NOT un | work done o | luring mo | N at of working | 161 | . KIND OF BUS | iness/indu | STRY | |
| 17. FATHER'S NAME (First, MANARE) Andre | | an | | | | | | A | KORA | N | | |
| 19e. INFORMANT'S NAME (| llespi | e | | 43/4 | Ocea | n P | nd Number or Rural NEA | Be. | | | _ | |
| 20e. METHOD OF DISPOSIT | (Specify) | | 20b. PLACI other | mincel | ch's | Ceme | etery, crematory or etery | | 20c. LO | Gumb c | | |
| 21. SIGNATURE OF PUREN | I all | lik | | | | | rich Fun | | Home. | Benl | lin, | Md. |
| immediate cause (FI disease or condition resulting in death) Sequentially list condi if any, leading to immediate. Enter UNDEAL CAUSE (Disease or in) | eart fallure. I | DUE 1 | ause on each ill | SEQUENCE (| DF): | | nfice | | | | | interval Betwee Onset and Deat I L acq |
| PART ii. Other aignific | ant condition | ds contributing | | t resulting | in the u | nderlyin | g cause given i | n Part I. | 24s. WAS AF PERFO 1 YES | RMEO? | 24b | WERE AUTOPSY FINDING AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED | TO MEDICAL | | | | | 26. F | LACE OF DEATH (| Check only | one) | | | |
| EXAMINER? | | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | OTHE | R: rsing Ho | ne 5 🗆 Residence | 8 🗆 Ot | her (Specify) | | | |
| 27. MANNER OF DEATH | Pending | 28a. DATE (Month | OF INJURY , Day, Year) | 28b. T | ME OF NJURY M | W | JURY AT ORK? YES 2 NO | 28d. D | EŞCRIBE HOW | INJURY OCC | URED | |
| 4 Homicide | Could not be determined | | E OF INJURY — A1 ng, atc. (Specify) | home, farm | , street, fac | ctory, offi | GO . | | OCATION (Street ity or Town, State | | or Rural | Route Number, |
| | | | | | | | e and place, and d | | | | | a) and manner as stated. |
| 29b. SIGNATURE AND TIT | E OF CERTIFIE | R 20 (0 | 0 ,,= | | | | 29c. LICENSE N | IUMBER | | 29d. DATE | Z ~ | (Month, Day, Year) |
| 30. NAME AND ADDRESS | | 10 COMPLETEO C | AUSE OF DEATH (| | | UAV | 68. | 511 | (, c/n/ | 04 | 41 | 2001 |
| | | | | | | | | | | | | |

Ria Savidson-Randell





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| 0 96 | irector, | |
| SPITAL DR ALLENDING PRISICIAN: The law requires that the beaut certained to executed within 27-yours arise beauting to may | VERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pa | |
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31. DATE 100 (MONEY), 801. 190

| | FOR 1 - STATE REGISTRAR | | STATE OF I | | | TMENT O | | EALTH AND I | MENTA | L HYGIEN REG. NO. | E | 90 | 34421 |
|---------------|--|----------------------------------|----------------------------------|--|---------------------|------------------|---------------|---|-------------------|---------------------------------------|----------------|---------------|--|
| | 1. OECEDENT'S NAME (First | , Middle, Last) | | | | | | | 2. DATE | OF DEATH | NY. | YEAR | TIME OF DEATH |
| | | LL | .OYD C | ALVERT | LE | ATHERE | BUR | lΥ | NOV | EMBER | 24, | 1990 | |
| STATE OF | 4. SOCIAL SECURITY NUM 218-14-412 | | 5. SEX | 6. AGE (In yrs.) | last birthday) YRS. | MONTHS DA | $\overline{}$ | IF UNDER 24 HRS. HOURS MIN. | 7. DATE (Monti | of BIRTH | | Country) | S ROAD |
| | 9a. FACILITY NAME (If not in | | street and number) | | | 9b. CITY, TO | WN O | R LOCATION OF DE | | , o, | _ | TY OF OEAT | |
| 5 | RESIDENCE OF DE | | SLAND RO | IAD | | WEST | ΟV | /ER | | | S | OMERS | ET |
| DIRECTO | 10a. STATE MD. | 106. COUNT SOMER | | | | Y, TOWN OR L | OCAT | TION | | | | | d. INSIDE CITY LIMITS? |
| | 10a. STREET AND NUMBER | | | | | : | 101. | . ZIP CODE | | | 10g. CITIZ | | T COUNTRY? |
| EB | | P.O. | BOX 103 | | | | 2 | 21871 | | | | USA | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 X 3 Widowed 4 Divi | | | NT EVER IN U.S. A I YES 2 S WAR OR DATES | | If yo | a, spe | ENDENT OF HISPAN ecify Cuban, Maxica 2 X NO Specify | n, Puarto | | | Black, V | American Indien, Thita, atc. |
| | 15. DEC | CEDENT'S EDU by highest grade | ICATION | 16a. | | USUAL OCCU | | | 186 | . KIND OF BU | SINESS/IND | USTRY | |
| COMPLET | Elementery/Secondery (| | College (1-4 or 5 | +) | LABC | se retired.) | ig 1770. | ot of worning | ME | STA | TE RO | ADS A | DM. |
| Š. | 17. FATHER'S NAME (First, A | Middle, Last) | UNKNO | NAIN1 | | | | 18. MOTHER'S NA | ME (First, | Middle, Malden | Surname) | | |
| BE | | | UNKING | JAALA | | | | | SAE | DDIE 1 | _EATH | ERBUR | Y-BELL |
| 2 | 194. INFORMANT'S NAME (CORRAINE D | Type/Print) ENNIS | | | | | | and Number or Rural I | | ber, City or Tow | rn, State, Zip | Code) | |
| | 20a, METHOD OF DISPOSI | | | 1 and 10 at | | | | AS ABOVE | | 20- 10 | CATION | City or Town | Pasta |
| | 1 Burial 2 Cremeta 4 Donation 5 Othe | | noval from State | S Tother | ##UL | UM CEN | 1ET | TERY | | | | RNON, | |
| | 21. SIGNATURE OF FUNER | | | | | 22. NA | WE AN | ND ADDRESS OF FA | CILITY | | | | |
| | Lord | the L | 3. Joi | ley | | SAL | IS | SBURY, MC | D. 2' | 1801 | | | BOX 920 |
| | 23. PART I. Enter the dehock, or I | heart fellure. | completione the Liet only one ce | et caused the suse on each li | death. Do ine. | not enter the | e mo | de of dying, suc | ch es car | dlec or reep | Iratory err | eet, | Approximete interval Betwee Oneet end Dec |
| | diseese or condition resulting in deeth) | \rightarrow | 0 | O (OR AS A CON | | | | | | | | | 9 MONT |
| TION | Sequentially list condi | ediate | b | O (OR AS A CON | SEQUENCE (| OF): | | | | | | | |
| CERTIFICATION | ceuse. Enter UNDERLY CAUSE (Disease or inj that initiated evente resulting in death) LA | ury | cDUE TO | O (OR AS A CON | SEQUENCE (| OF): | | | | | | | |
| | PART ii. Other eignific | ent conditio | d. | o death but no | t resulting | in the unde | rlying | a ceuse aiven in | Part i | 24a. WAS AF | VAUITORS | 245 W | ERE AUTOPSY FINDIN |
| MEDICAL | | | | | | | | | | PERFO | RMED? | o o | WAILABLE PRIOR TO OMPLETION OF CAUSI IF DEATH? |
| PHYSICIAN: | 25. WAS CASE REFERRED | TO MEDICAL | _ | | | | 26 DI | LACE OF OEATH (C) | hack anly o | l l l l l l l l l l l l l l l l l l l | | | |
| 泛 | EXAMINER? | | HOSPITAL: | ☐ E9/Outnetlant | 3 □ DOA | OTHER: | | ne 5 Presidence | | | | - | |
| H | 27. MANNER OF DEATH | | 26a. DATE C | F INJURY | 28b. TI | ME OF 28 | c. INJ | JURY AT | _ | SCRIBE HOW | INJURY OC | CURED | |
| ВУ Р | 1 Natural 5 | Pending investigation | | Day, Year) | " | M . | | ORK? YES 2 NO | | | | | |
| ED B | 0 0 0 1111 | Could not be detarmined | 28a. PLACE bullding | OF INJURY — At g, etc. (Specify) | home, farm | street, factory | , offic | | 28f. LO City | CATION (Street or Town, State | and Number | or Rural Rou | ite Number, |
| COMPLET | (Check only | RTIFYING PHY | SICIAN: To the best | of my knowledge | death occu | rred at the time | , data | and place, and du | e to the co | suse(a) and mi | inner aa stal | ted. | |
| ON | one) 2 ME | DICAL EXAMIN | IER: On the beals of | axamination and | or investigat | ion, in my opin | ilon, d | death occured at the | time, dat | a and pleca, a | nd due to th | na Cause(a) s | and manner as stated |
| BE | 29b. SIGNATURE AND TITI | E OF CERTIFI | h. A. | | il | (-D. | | 29c. LICENSE NU | | 4 | 29d, DAT | E SIGNEO (A | Aonth, Day, Year) |
| 2 | 30 NAME AND ADDRESS | OF PERSON W | HO COMPLETED CA | USE OF DEATH | ITEM 27) (%) | on. Print) | _ | | | | 1 | 1 | 1.0 |

PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

32. BEGISTRAP'S SIGNATURE

Julia Davidson Francest

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TO BE COMPLETED BY FUNERAL DIRECTOR

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. |
|--|
| THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 shou |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)

0EC 4 - '90

| | | | | | | | | | | 9 (|) 3 | 4425 |
|--|---------------------------------|-------------------|-------------|---------------------------|-----------|-------------------------|----------|--|------------|------------------|------------------------------|--------------------------|
| FOR S | TATE OF MA | RYLAND / | DEPAR | TMENT | OF H | EALTH | AND N | MENTAL HYGIENI | E | | | |
| REGISTRAR | | | | | | DEAT | H | REG. NO. | | | | |
| 1. DECEDENT'S NAME (First, Middle, Last) | JOHN I | | SOWS | KY, | JR. | | | 2. DATE OF DEATH | Y | SAB | 3. TIME OI | DEATH N |
| 4. SOCIAL SECURITY NUMBER 5. | SEX 8. | AGE (In yrs. lesi | t birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH | | | PLACE (Stat | te or Foreign |
| 214-54-4522 | M 2 □ F | 42 | YRS. | MONTHS | DAYS | HOURS | MIN. | (Month, Day, Year) 7-23-48 | | MA | RYLA | ND |
| 9a. FACILITY NAME (If not institution, give street | and number) | | | 9b. CITY | TOWN O | R LOCATIO | N OF DE | | 9c. COU | NTY OF D | EATH | |
| SINAI HOSPITAL | | | | В | ALT: | MOR | E | | BA | LTI | MORE | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN C | R LOCAT | ION | | | | | 10d. INSID | E CITY |
| MD CARR | OLL | | | W | ESTI | IINS | TER | | | | 1 TYES | |
| 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | V | | 10g. CIT | IZEN OF | WHAT COUN | TRY? |
| 81 DUTROW ROAD | | | | | | 211 | | | | S. | | |
| 11. MARITAL STATUS 12. 1 Never Married 2 Married | WAS DECEDENT E FORCES? 1 | | | | | | | IIC ORIGIN? (Specify Yea n, Puarto Rican, atc.) | or No- | 14, RACI Blac | E — America k, White, atc | in Indian, |
| 3 Widowed 4 Divorced | IF YES, GIVE WAR | OR DATES | | | 1 TYES | 2 X NO | Specify | r: | | Spec | "y: H T TE | |
| 15. DECEDENT'S EDUCATION | | | CEDENT'S | | | | | 16b. KIND OF BUS | INESS/IN | | 11212 | |
| (Specify only highest grade com Elamentary/Secondary (0-12) Co | oleted) ollege (1-4 or 5+) | (G. | Do NOT us | work done se retired.) | during mo | st of working | 9 | Health | n Ca | are | Admn | . for |
| | 2+ | MG | MT. | ANA | LYS | P | | Federa | | | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | ER'S NA | ME (First, Middle, Meiden | Sumame) | | | |
| JOHN PETER LISC | WSKY, | | | | | | | | TH | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | 191 | | | | | | Route Number, City or Town | | | | |
| JANET L. LISOWSK | | 20b. PLACE | | | | ROAD | | ESTMINST | | *** | 2115 own, State | 7 |
| 2(a, METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal 4 Donation 5 Other (Specify) | from State | other pl | ace) | | | | | | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENS | EE | CRES' | r LP | | | D ADDRES | | ARDENS E | Later C | OTT | CLT | Y, MD |
| • | | | | P | RIT | rs f | UNE | RAL HOME | | | | |
| ROBERT K. PF | | | | | | | | | | | NSTE | |
| 23. PART I. Enter the diseases, or com ahock, or heart fellure. List | | | | not enter | the mo | de of dyl | ng, suc | h as cardiac or raspi | ratory a | rrest, | Inte | roximate rvai Between |
| IMMEDIATE CAUSE (Final disease or condition | Dres | EMIN | ~ | | (10 | 00. | 6.0A. | 27, 81 C | | | Ons | et and Death |
| resulting in death) a | | AS A CONSE | QUENCE O | n: | | 12 CCA | 100 | 1655. | | | - 11 | |
| | CAN | non | 550 | RIT | TUR | 7/ | THE | 2655 | | | i i | |
| Sequentially list conditions, if any, leading to immediate | DUE TO (OI | AS A CONSE | | | | / | | | | | | |
| cause. Enter UNDERLYING CAUSE (Disease or injury | | | | | | | | | | | | |
| that initiated events resulting in death) LAST | DUE TO (O | AS A CONSE | OUENCE O | F): | | | | | | | - 1 | |
| d. | | | | | | | | | | | | 1 |
| PART II. Other aignificent conditions co | ontributing to de | ath but not i | resulting | In the u | nderlyin | cause g | jiven in | Part i. 24s. WAS AN PERFOR | | 24 | b. WERE AUT | OPSY FINDINGS |
| | | | | | | | | 1 YES 2 | | | | ON OF CAUSE |
| | | | | | | | | | | | 1 TYES | |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | | OTHE | | ACE OF D | EATH (Ch | eck only one) | 16 | - 0 | | / |
| 1 YES 2 NO | impatient 2 - E | | _ | 4 🗆 Nu | noH gnlar | e 5 🗆 Re | sidence | | 110 | 5617 | 112 | 1_ |
| 27. MANNER OF DEATH Therural 5 Pending | 28a. DATE OF IN (Month, Day, | | 28b. TIR | ME OF JURY | | URY AT PRK? YES 2 | l no | 28d. DEŞCRIBE HOW I | NJURY O | CCURED | | " met |
| 2 Accident Investigation | 28a. PLACE OF I | NJURY — Athr | ome, farm. | | | | NO | 281. LOCATION (Street : | and Numb | er or Rumi | Route Numb | |
| 3 Suicide 8 Could not be 4 Homicide determined | building, etc | . (Specify) | me | | iory, omi | • | | City or Town, State) | and Normal | 14 | TROUGHTONIA | |
| 29a. CERTIFIER CONFESSION PHYSICIAL | i: To the heat of | irnowledge d | ath cour | and at the | time des | and elec- | and de- | to the cause(a) and man | mer en et | atad. | | |
| (Check only one) 2 MEDICAL EXAMINER: C | - | | | | | | | | | | | or so stated |
| | | | | | | | | | | | al-and mann | |
| 29b, SIGNATURE AND TITLE OF CENTERIN | -/ | | | | | 29c. LIC | | | | Service and | (Month, Qu | |

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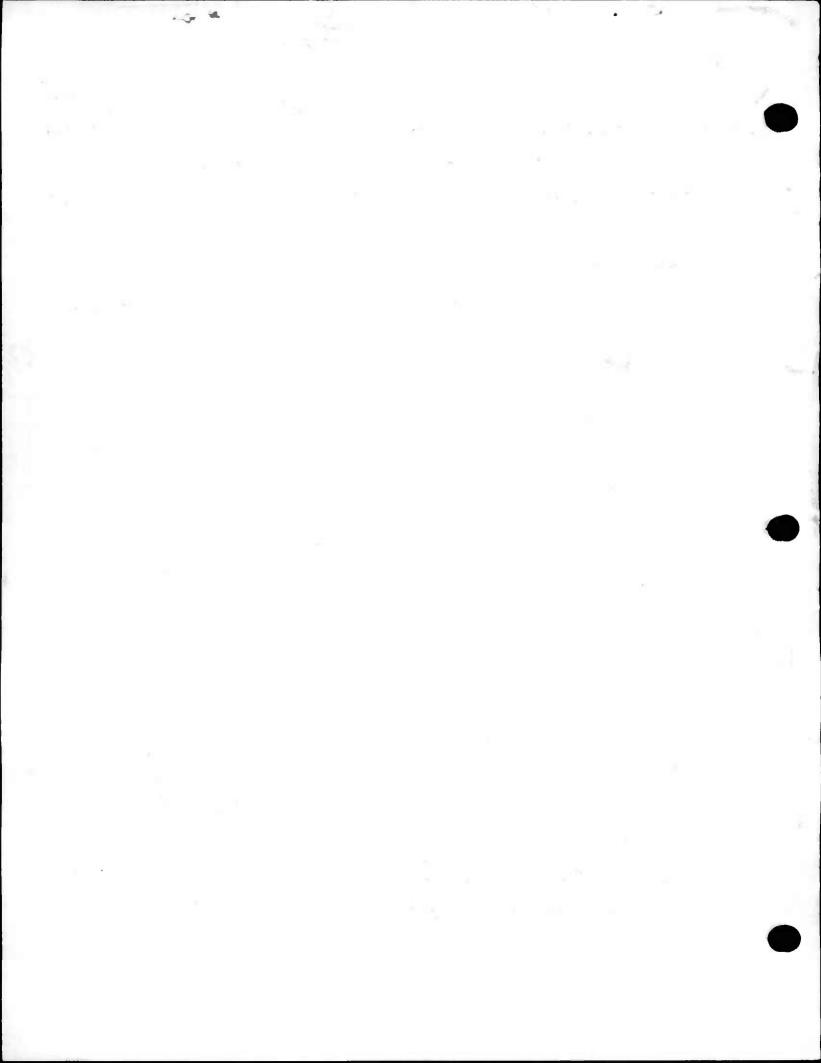
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| TO BE COMPLETED BY FUNE | TO BE COMO! ETED BY DHYSICIAN MEDICAL CERTIFICATION |
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| | IMPONIANI: II tem Lo is manaci, of tem Lo come in the |
| examiner must be notined at once. | IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notined at once. |
| A | be filed within 72 nours arief dearn with the State Dept. or nearly amount in your price of the state of the |
| | O HILL TOTAL OF THE STATE OF TH |
| he runeral director, page 5 should be detached for use as the burrantialist | m the ninepal high confidence has been signed by the attending physician and completely filled in by the truncal director, page 3 should be detached for use as use considered to the confidence of the confidence |
| | O THE HUSPITAL ON ALTENDING PHILOGRAPH. THE NAME OF THE PROPERTY OF THE PROPER |
| r death. Page 6 may be retained by the hospital or attending physician. | Language of any be retained by the hospital or attending physician. |
| | |

34426 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. FOR STATE REGISTRAR 1 -3. TIME OF OEATH 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) YEAR 811 STANTON LOMAX 11 7. DATE OF BIRTH (Month, Day, Year) 8. BIRTHPLACE (State or Foreign IF UNDER 1 YEAR IF UNDER 24 HRS. 4. SOCIAL SECURITY NUMBER Wash., D.C. DAYS HOURS MIN. 1 MM 2 - F Prince 6 9b. CITY, TOWN OR LOCATION OF DEATH el Beltsvilla Hospital George FUNERAL DIRECTOR IOd. INSIDE CITY 1 X YES 2 | NO WASHINGTON 10g. CITIZEN OF WHAT COUNTRY? 10e. STREET AND NUMBER SPRING 20010 U.S.A. N.W. Koad 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 11 VES 2 NO IF YES, GIVE WAR OR DATES 8/19/43 - 11/6/45 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or NoIf yes, specify Cuban, Maxican, Puerto Rican, etc.)

1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, atc. 11. MARITAL STATUS 1 Never Married Black ВҰ 3 Wildowed 4 Divorced BE COMPLETED 18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INDUSTRY Elementary/Secondary (0-12) College (1-4 or 8+) Private Industry Manager 12th 18. MOTHER'S NAME (First, Middle, Malden Surname) 17. FATHER'S NAME (First, Middle, Last) Bessie Banks Clifford Lomax 19b. MAILING ADORESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10a INCORMANT'S NAME (Type/Print) 2 BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| Lillie Mae Lomax | 1356 Sp | 1356 Spring Rd., N.W. Wash., D.C. 20010 | | | | | | | | |
|--|---|---|---|-----------------------------------|--|--|--|--|--|--|
| 20g, METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITIO | N (Name of cametery, crematory or | | 1 — City or Town, State | | | | | | |
| 1 XBuriel 2 Cremation 3 Removal from State | other place) Harmony Me | morial Park | Lando | ver, Maryland | | | | | | |
| 21. SIGNATURE OF PUNITRAL SERVICE LICENSEE | _ | 22. NAME AND ADDRESS OF FA | Johnson & | Jenkins, Inc. Wash., D.C. 2001 | | | | | | |
| 23. PART I Enter the diseases, or complications that ca shock, or heart failure. List only one ceuse | used the death. Do not on each line. | | | | | | | | | |
| IMMEDIATE CAUSE (Finel disease or condition resulting in death) . MyoCa | udial Int | artion | ··· | minutes | | | | | | |
| If any, leeding to immediate cause. Enter UNDERLYING | AS A CONSEQUENCE OF): AS A CONSEQUENCE OF): AS A CONSEQUENCE OF): | artion c CARBINASC | CULAR DISE. | ASE years | | | | | | |
| PART II. Other algoriticant conditions contributing to de States Part Coronaugar | . // . | | Part I. 24s. WAS AN AUTO PERFORMED 1 YES 2 N | AVAILABLE PRIOR TO | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C) | heck only one) | | | | | | | |
| EXAMINER? NO 1 Inpatient 2 DE | | THER: ☐ Nursing Home 5 ☐ Realdence | 8 Other (Specify) | | | | | | | |
| 27. MANNER OF DEATH 1 Netural 5 Pending Investigation | JURY 28b. TIME O | | 28d. DEŞCRIBE HOW INJUR | Y OCCURED | | | | | | |
| 2 Appropria | HJURY — At home, farm, stre. . (Specify) | ot, factory, office | 28t. LOCATION (Street and N City or Town, State) | umber or Rural Route Number, | | | | | | |
| 29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my one) 2 MEDICAL EXAMINER: On the best of exam | | | | | | | | | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER DE | Ny Midel | | 52) | 1. DATE SIGNED (Month, Day, Year) | | | | | | |
| Pay A. DE VORE, MD 4 | of DEATH (ITEM 27) (Type, Pr | bury Rd Hy | attsuille 1 | 18005 GA | | | | | | |
| NOV 27 90 Such Daird | signature | | | | | | | | | |
| | • | | | DHMH-18 Rev 1/8 | | | | | | |



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL

| - STATE REGISTRAR | 011112 01 11 | CER | TIFICATE | OF DE | | | G. NO. | | |
|---|------------------------------------|---|---------------------------------------|-----------------|-------------------------|-----------------|-----------------------------|-------------------|---|
| 1. DECEDENT'S NAME (First, Middle, Last) | | | Luszc | | | 2. DATE OF D | EATH DAY | YEAR | 3. TIME OF DEATH |
| JOSEPH | | 4NC15 | | ZCZ | - | 11 | 2/ | 40 |) F M |
| | 5. SEX 1)2 M 2 🗆 F | 6. AGE (In yrs. lest bir | thday) IF UNDER MONTHS | DAYS HOUR | NDER 24 HRS. PS MIN. | 7. DATE OF BI | Yeary | Countr | |
| 9a. FACILITY NAME (If not institution, give stre- | 27 | - 1 | | TOWN OR LOC | ATION OF DE | 1/07 | | INEW | York |
| | 10E | | | np/e | · LL | :11- | 0 | | |
| RESIDENCE OF DECEDENT | 100 | | 1.0 | npje | - 15 | 113 | | Inco | George |
| 10a. STATE 10b. COUNTY | - 600 | | c. CITY, TOWN O | | 11.1 | 1 - | | | 10d. INSIDE CITY LIMITS? |
| | ceoe | orge | Tem | | | / 5 | | | 1 TES 2 NO |
| 100. STREET AND NUMBER | مدرجر | | | 101. ZIP 0 | | | 10g. CI | | VHAT COUNTR∜? |
| 177 | Of NE | T EVER IN U.S. ARMED | Lan | | 0748 | | | US | |
| 1 Never Married 2 Married | FORCES? 1 | AR OR DATES | - 9 | yes, specify C | uban, Maxican | , Puarlo Rican | ecify Yee or No— , atc.) | 14. RACE Black | E — American Indian, k, Whita, atc. |
| 3 Widowed 4 Divorced | WWII | | ' | ☐ YES 2 DC | NO Specify: | • | | Speci | 34, TR |
| 15. DECEDENT'S EDUCA (Specify only highest grade co | TION (moleted) | 16a. OECEE | ENT'S USUAL OC | CUPATION | nekina | 18b. KING | OF BUSINESS/IP | IDUSTRY | |
| | College (1-4 or 5 + | iife. Do | and of work done on NOT use retired.) | ornig most of w | Orang | | | | |
| 12th | N/A | Print | er | | | _ | lf-Empl | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | 18. A | | | o, Malden Surname) | | |
| Stephen Luszcz | | T | | | | lia I | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | mber or Rural R | loute Number, C | ity or Town, State, 2 | Sip Code) | |
| Mable Luszcz 209. METHOD OF DISPOSITION | | | me as 1 | | omercia- | - 1 | 20c. LOCATION - | Otto | Chate |
| 1 Buriel 2 Cremation 3 Remov | al trom Stata | other place) | | | , | | | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE , | - Marytan | | VETEL | | | | | me, Maryland ome, Inc. |
| •9 | 10 | | | | | LIC | | | nton, Md 207 |
| Jenjanno 6 | 20 | Alas | | | | | | | 10011, PM 207 |
| 23. PART I. Enter the diseeses, or co ahock, or heart failure. Li | mplications the st only one ceu | t ceused the death Jee on each line. | . Do not enter | the mode of | dying, such | aa cardiac | or respiratory a | rreat, | Approximate interval Between |
| IMMEDIATE CAUSE (Final disease or condition | | | | - | | | | | Onset and Death |
| reaulting in deeth) | myo | cardia | 1 /h | ture | 4700 | 7 | | | Minutes |
| | A. ** | Cardia Or as a conseque | NCE OF): | Tindian | 10.10.1 | Kan | cania | | 14001.0 |
| Sequentially list conditione, | OUE TO | (OR AS A CONSEQUE | NCE OF): | PAIUN | ef Cur | ar w | JEENE | | TEANS |
| if any, leading to immediate ceuse. Enter UNDERLYING | | | 20 20 | | | | | | ļ |
| CAUSE (Disease or injury that initiated events | DUE TO | (OR AS A CONSEQUE | NCE OF): | | | | | | |
| reaulting in death) LAST | | | | | | | | | |
| PART II. Other eignificent conditions | contributing to | death but not rea | ulting in the up | derlylna cau | ee alves la l | Part I 24a | . WAS AN AUTOPS | v 244 | WERE AUTOPSY FINDINGS |
| - In the state of | contains to | Goddin Dot Hot Tool | nang in the or | dellying cau | ac given in i | Pert 1. 24s | PERFORMED? | 240 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | | | | | | 1 | YES 2 NO | | OF DEATH? |
| | | | | | | — I | | | 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | · · · · · · · · · · · · · · · · · · · | | 26 DI ACE (| OF DEATH (Che | ok onti onal | | | |
| EXAMINER? | HOSPITAL: | ☐ ER/Outpetient 3 ☐ | OTHER | ₹: | | | ine. | | |
| 27. MANNER OF DEATH | 28a DATE OF | IN HIRY 2 | 8b. TIME OF | 28c. INJURY A | | | BE HOW INJURY O | CCUREO | |
| 1 Natural 5 Pending | (Month, E | Day, jibar | INJURY M | WORK? | | | | 0001120 | |
| 2 Accident Investigation 3 Suicide & Could not be | 28e. PLACE C | OF INJURY — At home. | farm, street, faci | | | 281, LOCATIO | N (Street and Numb | per or Rural | Route Number, |
| 4 Homicide 8 Could not be detarmined | building, | , etc. (Specify) | | | | City or To | | | |
| 29a. CERTIFIER 1 CERTIFYING PHYSICI | AN: To the heat or | f my knowledge, death | accurred at the 4 | me date and - | dana and du- | to the owner's | and marros as | totad | |
| (Check only one) 2 MEDICAL EXAMINER: | | | | | | | | | e) end menner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | | LICENSE NUM | | | | |
| P. Millacha | 4.0 | Deputy | - COLLA | | >0 / | 5 | | | (Month, Day, Year) |
| 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALL | SE OF DEATH (ITEM 2 | (Type. Print) | | | 0-1 4 | | | 1-40 |
| Pala DeV. | 44 | 4703 | | | 1-1 | 11 . | 40.11 | . 11 | 120781 |

urs after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HISPIAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

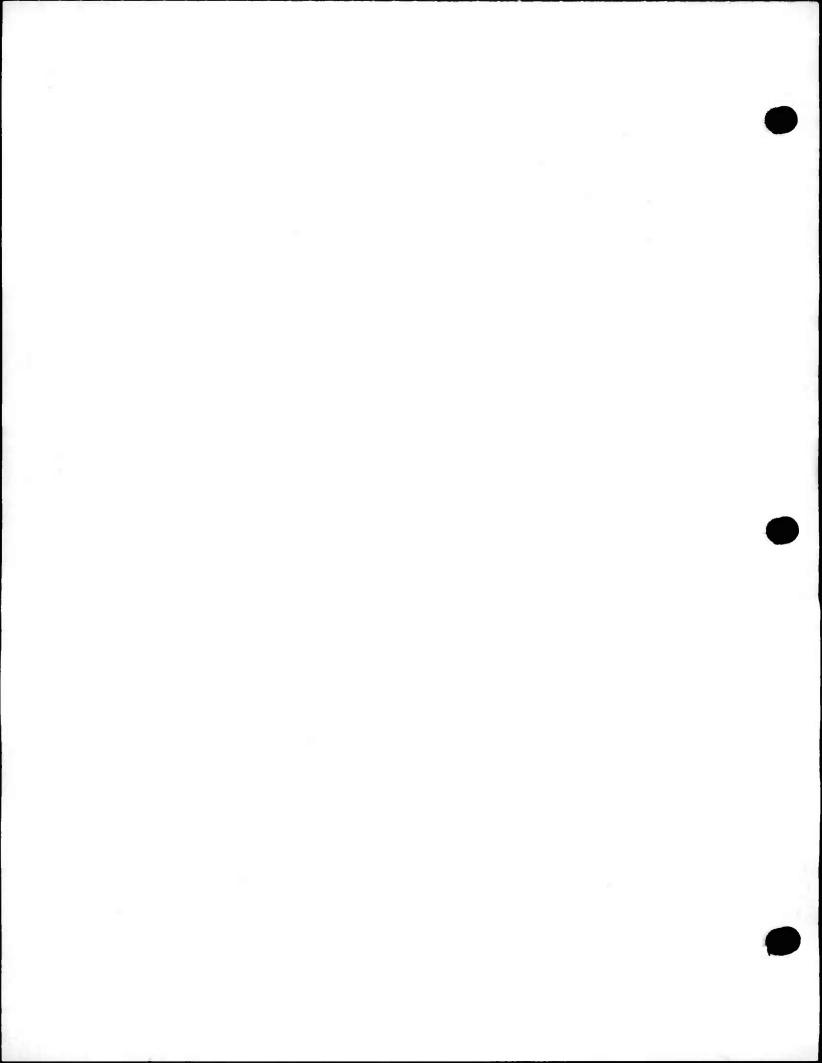
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

31. DATE FILED (Month, Day, Year)
NOV 2 9 90

Davidson Randale

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal.

OHMH-18 Rev 1/89



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| | rmit. |
| | 9 |

BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit pe be fled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. ours after death. Page 6 may be retained by the hospital or attending physician. TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First, Middle, Lest) 2. DATE OF DEATN MONTH DAY YEAR 3. TIME OF DEATN | | | | | | | | | | | |
|--|-------------------------------|------------------|-------------------|---------------------|-------------------------|--------------------------|--------------|---------------|----------|--|--|
| LILLIAN ELI | ZABETH | LEYSH | ION | | | Dec. | | 199 | | 230 a.m. | |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yr. | s. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF I | | | 8. BIRTH | PLACE (State or Foreign | |
| 170-10-0043 | 1 🗆 M 2 🖵 F | 89 | YRS. | MONTHS DAYS | HOURS MIN. | Apr. 6 | | ו דב | | nsylvania | |
| 9a. FACILITY NAME (If not institution, give s | treet and number) | Cer | iter | 9b. CITY, TOWN | OR LOCATION OF DE | | | 9c. COUN | | | |
| Pleasant Livin | g Conva | alesce | ent | Ed | gewater | | | Ann | e A | rundel | |
| 10a. STATE 10b. COUNTY | 1 | | 10c. CIT | Y, TOWN OR LOC | ATION | | | | | 10d. INSIDE CITY | |
| Maryland Anne | Arunde | .7 | Ed | lgewate | a r | | | | | LIMITS? 1 YES 2 NO | |
| 10s. STREET AND NUMBER | Alund | - | 12/ | | Of. ZIP CODE | | | 10g. CITIZ | EN OF V | VHAT COUNTRY? | |
| 744 Wookington | Dood | | | | 21037 | 7 | | U | .s. | Α _ | |
| 144 Washington | 12. WAS OECEDE | NT EVER IN U.S | S. ARMED | 13. WAS DI | ECENDENT OF HISPAI | | Specify Yea | | | | |
| 1 Never Married 2 Married FORCES? 1 YES 2 NO It yes, specify Cuban, Maxican, Puerio Rican, atc.) Black, Whita, atc. Specify: Specify: | | | | | | | | | | | |
| 3 ™ Widowed 4 □ Divorced | | | | | | | | | | | |
| 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 18: | DECEDENT'S | USUAL OCCUPAT | TION | 16b, KII | ND OF BUS | INESS/INDU | | | |
| Elementary/Secondary (0-12) | College (1-4 or 5 | +) | ille. Do NOT us | se retired.) | nost or working | | | | | | |
| 7.2 | | | Homen | naker | | | Hom | е | | | |
| 17. FATNER'S NAME (First, Middle, Last) | | • | | | 18. MOTHER'S NA | AME (First, Midd | de, Maiden | Surname) | | | |
| David Morgan | Thomas | | | | Rache | el Tho | omas | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | - II O III w D | | 19b. MAILING | ADDRESS (Stree | t and Number or Rural | | | n, State, Zip | Code) | | |
| Patricia H. Wi | lliame | | 455 | Honer | eng Trai | 1. A | nnan | olis | . M | D 21401 | |
| 20s. METHOD OF DISPOSITION | ACCUSED OF THE REAL PROPERTY. | 20b. PL | | | cemetery, crematory or | | | CATION — C | | | |
| 1 Burial 2 Cremation 3 Ram 4 Defation 5 Other (Specify) | oval from State | ing | place) | | Cremato | 27. | | | | , VA | |
| 21 SIGNATURE OF FUNERAL BEGVICE LIC | DENSEE | - I ive | POPO. | 22 NAME | AND ADDRESS OF SA | CILITY | | | 110 | | |
| 0 6 0 1 | 1 | 1 | | Tay | lor Fune | eral (| Chap | el | | 21401 | |
| anales & | · Lky | /w | | 147 | Glouces | ster S | St., | Anna | pol | is,MD | |
| 23. PART I. Entar the diseases, or | | | | not antar tha n | noda of dying, aud | ch aa cardiad | or reapl | ratory arre | eat, | Approximata | |
| ahock, or haart failure. IMMEDIATE CAUSE (Final | List only one ca | uaa on aach | ilna. | | | | | | | Interval Between Onest and Death | |
| disease or condition | e l | - 1 | | | | | | | | Wha | |
| resulting in death) | a. DUE TO | O (OR AS A CO | INSEQUENCE O | PD: | | | | | | 19. | |
| _ | | | | | | | | | | j | |
| Sequentially list conditions, | b DUE TO | O (OR AS A CO | NSEQUENCE O | PF): | | | | | | | |
| If any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | | | |
| CAUSE (Disease or injury that initiated events | CDUE TO | O (OR AS A CO | NSEQUENCE O | PF): | | | | | | | |
| reaulting in death) LAST | | | | | | | | | | | |
| | d | | | | | | | _ | | | |
| PART II. Other aignificant condition | na contributing t | o daath but | not phaulting | in the underly | ing cause given in | Part i. 24 | Ia. WAS AN | | 241 | D. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| SIP bitche | nd an | mut | timo | 11 | 940 | | ☐ YES 2 | | | COMPLETION OF CAUSE OF DEATH? | |
| , , | | U | | | 0 | | | | | 1 YES 2 NO | |
| | | | | -1 | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL | | | | 28. | PLACE OF DEATN (C) | heck only one) | | | | | |
| EXAMINER? | HOSPITAL: | □ EB/Outhout | nt 3 DOA | OTHER | | | Danalli 3 | | | | |
| 27. MANNER OF DEATH | 28a. DATE C | | 28b. TIR | | oma 8 - Residence | 28d. DESCR | | NJURY OCC | URED | | |
| 1 Natural 5 Pending | | Day, Year) | | JURY | WORK? | | | | | | |
| 2 Accident Investigation | 28a DI ACE | OE IN HIP | At home fear | street, fectory, of | | 284 1 0047 | ON /Street | and Number | or Burn' | Route Number. | |
| 3 Suicide 6 Could not be 4 Nomicide determined | | , atc. (Specify) | AL HOME, TECHI, | acreet, rectory, or | inca | | Town, State) | | or muren | noute Number, | |
| | | | | | | | | - | | | |
| 29a. CERTIFIER 1 CERTIFYING PHYS | | | | | | | | | | | |
| one) 2 MEDICAL EXAMIN | ER: On the beels of | axamination ar | nd/or investigati | on, in my opinior | n, death occured at the | a ti <i>m</i> a, data an | d placa, an | d due to th | a cause | (a) and manner as stated. | |
| 296. SIGNATURE AND TITLE OF CERTIFIE | R | 1 | | | 29c. LICENSE NU | JMBER | | 29d. DATI | E SIGNE | D (Month, Day, Year) | |
| Joseph () I | MALN | 1 1 | 1-11 | | 10170 | 764 | | 1 | 2/3 | 3196 | |
| 30. MAME AND ADDRESS OF PERSON W | HO COMPLETED CA | USE OF DEATH | 1 (ITEM 27) (Typ | e, Print) | 1 1 1 | , = , | | | 1 | 1 | |
| Joseph. A | 1- Frie | M | 20 | 5 Pa | djely | Ave | j | m | 201 | is un. | |
| DEC 04 1990 | give Day | AR'S SIGN | 积000 | | | | | | 0 | , , | |

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TO BE COMPLETED BY FUNERAL DIRECTOR

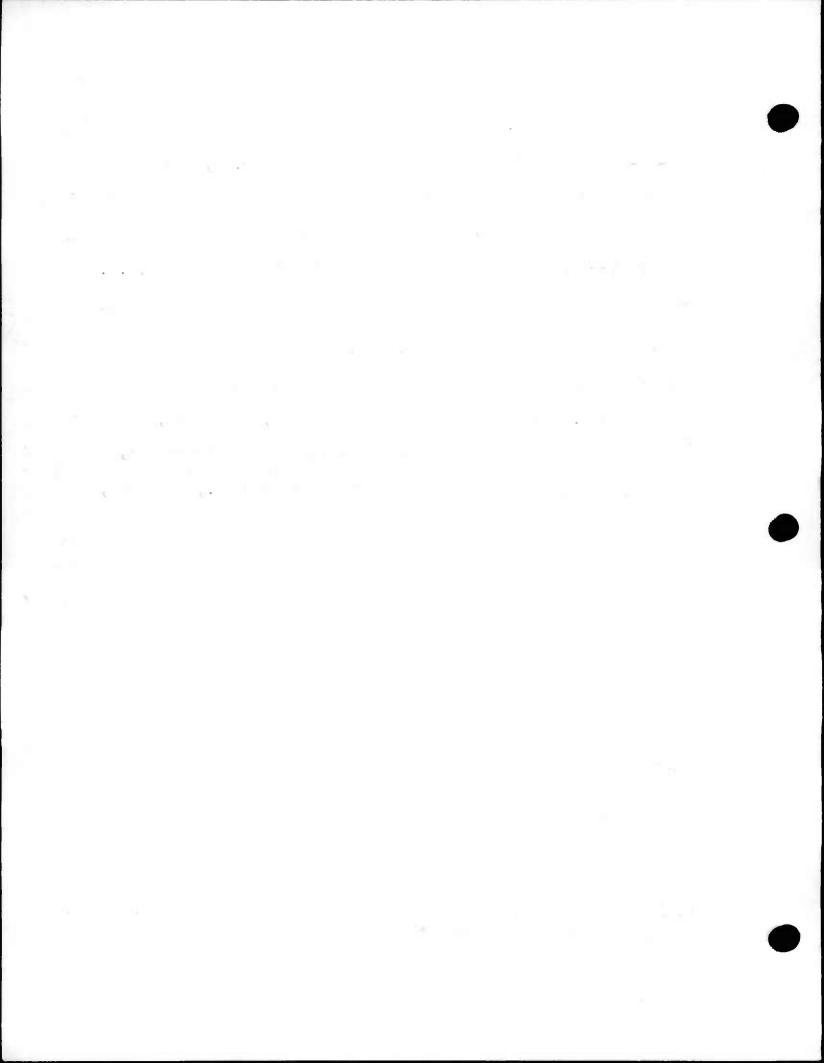
| 7 | • | - | | |
|---|---|---|---|--|
| | | ages | | |
| DIVISION OF VIAL PECONDS, 1.0. DOX 10.10, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | m THE FINERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages | he find within 72 hours after death with the State Dept. or Health and Mental Hygiene prior to burial, cremation, or removal. | and the model of second and secon |

IMPORTANT: It liem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| FOR STATE REGISTRAR | STATE OF I | MARYLAND / DEPAR CERTIF | TMENT OF H | |
|---|------------|---------------------------------|----------------|--------------------|
| ECEDENT'S NAME (First, Middle, Last) JEANNE' | TE H.L | EE | | |
| and and the state of the state | c orv | C ACE the same to as bloth days | E UNDER 4 VEAR | IN THIS PRO SA MOR |

34429 90

| | 1 - FOR STATE OF MAI | RYLAND / DEPAR CERTIF | TMENT OF | HEALTH AND I | MENTAL HYGIENE REG. NO. | 90 | 34429 |
|------------------|--|---|------------------------------------|---|--|------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) JEANNETTE H. LEI | 2 | | | 2. DATE OF DEATH MONTH DAY | 1990 | 3. TIME OF DEATH |
| | 4, SOCIAL SECURITY NUMBER 5. SEX 6. | AGE (In yrs. lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT Coun | HPLACE (State on Foreign |
| | 220-24-1432 1 M 25 F | 77 YRS. | | | Mar. 25,19 | | aryland |
| ~ | 9a. FACILITY NAME (If not institution, give street and number) | α . | | OR LOCATION OF DE | АТН | 9c. COUNTY OF | |
| Ē | Anne Arundel Medical | Genter | Ann | apolis | | Anne | Arundel |
| H H | 10e. STATE 10b. COUNTY | 1,124 | Y, TOWN OR LOC | | | | 10d. INSIDE CITY LIMITS? |
| <u> </u> | Maryland Anne Arund | el L | Edgev | vater or, zip code | T | 10a CITIZEN OF | 1 YES 2 NO |
| RA | | | | 21037 | | U.S | |
| FUNERAL DIRECTOR | 1017 Wier Road 11. MARITAL STATUS 12. WAS DECEDENT E | | | ECENDENT OF HISPAI | IIC ORIGIN? (Specify Yee | | CE — American Indian, ick, White, atc. |
| BY FI | 1 Never Merried 2 Merried FORCES? 1 IF YES, GIVE WAR | | | specify Cuben, Mexice S 2 XNO Specif | | Spe | ecify: |
| | 15, DECEDENT'S EDUCATION | 16e. DECEDENT'S | LISUAL OCCUPA | TION | 16b. KIND OF BUSI | | nite |
| COMPLETED | (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4 or 5 +) | (Give kind of life, Do NOT us | work done during i se retired.) | nost of working | log kind of Book | | |
| PL | 12 | Home | maker | | Home | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | ME (First, Middle, Maiden S | Surname) | |
| BE (| William Burgess | | | | Kirby | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | Route Number, City or Town | | 0 27027 |
| | Van Orden T. Lee | 20b. PLACE OF DISPO | | | , Edgewat | CATION — City or | |
| | 1X) Buriet 2 Cremetton 3 Removal from State 4 Donation 5 Other (Specify) | | h Came | tarv | Bird | sville | e. MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | 22. NAME | AND ADDRESS OF F | ral Chape | •] | 21401 |
| | (Valle C. am | ner | | | ter St., | | |
| | 23. PART I. Enter the dissasea, or complications that a shock, or hasrt failure. List only one cause | jussed the death. Do | not satsr the I | moda of dying, au | ch as cardiac or respi | ratDry arreat, | Approximats interval Batween |
| | IMMEDIATE CALISE /Finei | | | 1, | | | Onset and Dasth |
| | disesse or condition reaulting in death) | OG ENIC | Shoc | K | | | 2.412 |
| | _ A . T | e ander | TOIC L | wall | ME | | 12 hrs |
| O. | Sequentisity list conditions, if sny, isading to immediate | R AS A CONSEQUENCE | DF): | 1- | | | 101 |
| CAT | csuse. Enter UNDERLYING CAUSE (Disease or injury | R AS A CONSEQUENCE C | Tory . | disease | | | 10 1/5 |
| TIFI | that Initiated svents resulting in daath) LAST | R AS A CONSEQUENCE (| OF): / | | | | |
| CERTIFICATION | d | | | | | | |
| CAL | PART ii. Other aignificent conditions contributing to d | ssth but not resulting | In the underly | ring csuse given Ir | Part i. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| 20 | | | | | 1 YES 2 | □ NO | OF DEATH? |
| Z | | | | | | | 1 NES 2 NO |
| PHYSICIAN: MEDI | 25. WAS CASE REFERRED TO MEDICAL | | 28 | PLACE OF DEATH (C | heck only one) | | |
| SICI | EXAMINER? 1 YES 2 NO 1 Thingstient 2 | ER/Outpatient 3 DOA | OTHER: | iome 5 - Residence | 8 Other (Specify) | | |
| λΗζ | 27. MANNER OF DEATH 28e. DATE OF II (Month, Day | | ME OF 28c. | INJURY AT WORK? | 28d. DEŞCRIBE HOW I | NJURY OCCURED | , |
| BY F | 1 Hatural 5 Pending 2 Accident Investigation | | | YES 2 NO | | | |
| | 3 Suicide 6 Could not be determined | INJURY — At home, farm lc. (Specify) | , atreet, factory, o | office | 28f. LOCATION (Street of City or Town, State) | and Number or Ru | rai Houte Number, |
| H | | | | | | | |
| COMPLETED | 296. CERTIFIER 1 DERTIFYING PHYSICIAN: To the best of n (ne) one) 2 MEDICAL EXAMINER: On the best of examiner. | | | | | | se(e) end menner ee stated. |
| | 29b. SIGNATURE AND TITLE OF CENTIFIER | / | | 29c. LICENSE N | | | NED (Month, Day, Year) |
| BE | mach M Frier | 1 | | 017 | 765 | 12/6 | 5190 |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE | 200 | Ridge | /4 Av- | e Ann | wells | Md. 2144 |
| | 31. DATE FILED (Mdg/h, Day, Year) DEC 0 7 1990 Julia Day | S SIGNATURE TO BE | | | | 0 | |



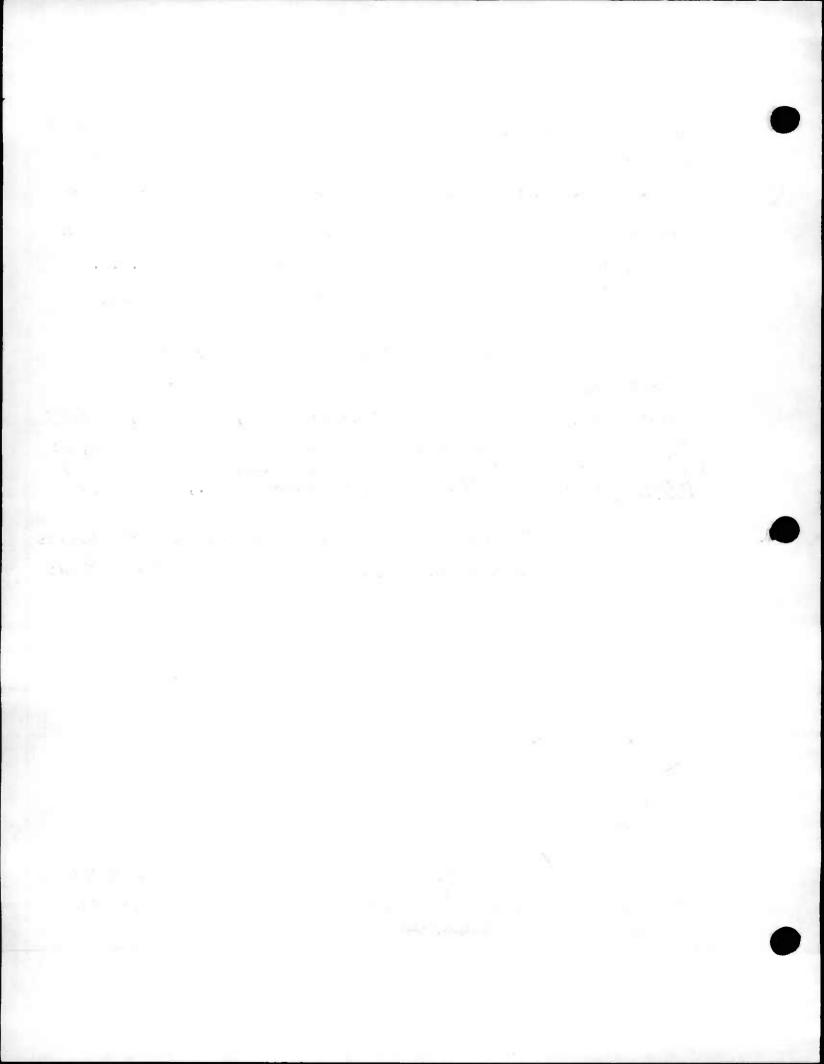
| 1 | 9 |
|----|---------|
| (6 | |
| | Pages |
| | permit. |

BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit is find within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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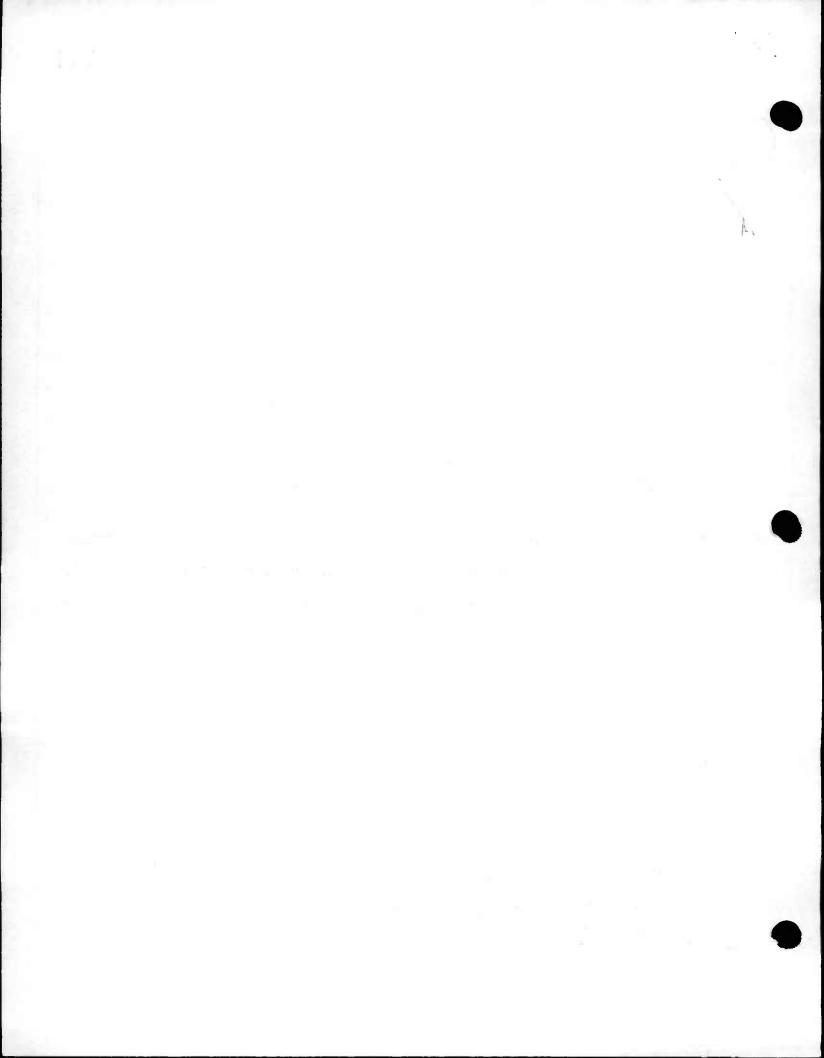
| | REGIOTRAN | | | | | · DEATH | | TIEG. NO. | | | | |
|------------------------------|---|--|--|---------------------------------------|--|---|--|--|--|--|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | DATE OF DEATH | | VEAR. | 3. TIME OF DEATH | |
| | - Tau | N Eu | dakin | 1.01 | SULI | | 1 | IZ 4 | | YEAR | 1:30 PM | |
| | | | MINOP | | | | | | | | 1 | |
| 1 | 4. SOCIAL SECURITY NUMBER | 5, SEX | 6. AGE (In yrs. last | | IF UNDER 1 YEA | | | DATE OF BIRTH (Month, Day, Year) | _ | 6. BIRTH | PLACE (State or Foreign | |
| | 063-10-7326 | M 2 DF | 78 | YRS. | MONTHS DAY | S HOURS MI | 0 | 910 19 | 1/2 | | ssia | |
| | | | | - | OF CITY ACT | N OR LOCATION O | E DE IT | | 90 00114 | | | |
| 1 | 9a. FACILITY NAME (If not institution, give stre | eer and number) | | - 1 | | | PEATH | The state of the s | | | | |
| 8 | Anna Anundal 1 | ren i ha M | Cente | r | Anr | apolis | | Anne Arundel | | | | |
| K | Anne Arundel I | | - Jente | • | 40111 | 0110 | | | | | | |
| M | 10a. STATE 10b. COUNTY | | | | TOWN OR LO | CATION | | | | | 10d. INSIDE CITY LIMITS? | |
| ۳ ا | N | Α 1 | | Α | | ÷ - | | | | | 1 YES 2 NO | |
| 0 | | e Arund | ет | An | napol | | _ | | | | | |
| A I | 10. STREET AND NUMBER | | | | - 1 | 101. ZIP CODE | | | 10g. CITI | ZEN OF W | VHAT COUNTRY? | |
| FUNERAL DIRECTOR | 901 Bridgepo | rt Cour | t. | | - 1 | 214 | 01 | | | U.S | . A . | |
| Z I | 11. MARITAL STATUS | 12. WAS DECEDEN | | MED | 13 WAS | | | ORIGIN? (Specify Yea | or No. | 14. RACE | - American Indian. | |
| E | 1 Never Married 2 Married | FORCES? 1 | YES 2 N | | If yes | specify Cuban, Ma | xicen, P | | | Black | c, White, etc. | |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE W | AR OR DATES | | 10 | YES 2 X NO S | oecify: | | | Speci | | |
| | 3 Wildowed 4 Divorced | | | | 1 | | | | | Whi | te | |
| | 15. DECEOENT'S EDUC | | 16a. DEG | CEDENT'S | JSUAL OCCUP | ATION | | 16b. KIND OF BUS | SINESS/IND | USTRY | | |
| EI | (Specify only highest grade of | | life | ve kind of w Do NOT use | ont done during a retired.) | most of working | | | | | | |
| ا ت | Elementary/Secondary (0-12) | College (1-4 or 5+ | | CI. | | | | Dharm | 0.0 | . 4 4 - | | |
| 을 l | | 5 + | • | Chem | ist | | | Pharm | | ITIC | al | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER" | S NAME | (First, Middle, Maiden | Surname) | | | |
| | Eudokim Logan | | | | | Ana | fia | Pupkev | ich | | | |
| 出 | | | Τ | 88812 2000 | ADDRESS (C) | | | | | Cod-1 | | |
| ٩ | 19a. INFORMANT'S NAME (Type/Print) | | 1 | | | | | Number, City or Tow | | | | |
| F | Stella Logun | | 9 | 01 B | ridge | port C | our | t, Anna | poli | LS, | MD 21401 | |
| | 204. METHOD OF DISPOSITION | | | | | f cemetery, crematory | | | CATION - | | | |
| | 1 Burlei 2 Cremation 3 Ramo | oval from State | | | | | | | | | | |
| - 1 | 4 Donation 5 Other (Specify) | | / Latk | emon | | netery | | Davidsonville, MD | | | | |
| 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | ERSEE / | // | | 22. NAM | E AND ADDRESS O | F FACILI | al Chap | - 7 | | 27.407 | |
| 4 | 11 11 1 | . 7 | 4 | | | | | | | | | |
| | TALOVAL Y. | My | 100 | | 14' | Glouc | est | er St., | Anna | apol | is,MD | |
| 10.0 | 23, PART I. Enter the diseases, or c | omplications tha | at caused the de | ath. Do n | ot antar tha | mode of dving. | such a | a cardlec or respi | iratory en | rest, | Approximate | |
| | shock, or heart fellure. I | | | | | | | | | | Interval Batween | |
| - 1 | IMMEDIATE CAUSE (Final | | | | | | | | | | | |
| | INNEDIALE GROSE (I III | 14 | 4.9 | | | _ | 1 | | 1 | | Onset and Daath | |
| | disease or condition | Min | 7-0 | P (-A | A) F | AJLUR | E G | BENAL F | LEPA | 1770 | Onset and Daath | |
| | disease or condition resulting in death) | . Muli | TZ-O | RGA | NF | ATLUR | E (T | PENAL A | LEDA | 1770 | Onset and Daath | |
| | disease or condition resulting in death) | MULT DUE TO | O (OR AS A CONSEC | RGA DUENCE OF | NF | AJLUR | E (T | PENAL F | SEPA CHAR | 177 C | Onset and Death | |
| N | disease or condition resulting in death) | MULT DUE TO SEPS | O (OR AS A CONSECUTION PE | RGA OUENCE OF | DE ATE | AJLUR B Cou | E (T | Pulm. | SEPA | 1770 | Oneet and Daath 10 DAYS 4 WKS | |
| NOIL | | DUE TO SEPS OUE TO | O (OR AS A CONSECUTION OF | RGA DUENCE OF ERFO QUENCE OF | DE ATE | AJLUR B Cou | E (T | PULM. | SEPA | 177 (Y) | Onset and Daath ODAYS 4 wks | |
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| שלאו וואסוור, וואטוו באות | fter death. Page 6 may be retained by the host | the funeral director, page 5 should be detached | al examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, 7:0: BOX 13149, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 mars after death. Page 6 may be retained by the host | TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to the following the funeral director, page 5 should be detached to the following the funeral director, page 5 should be detached to the following the funeral director, page 5 should be detached to the following the funeral director, page 5 should be detached to the following the funeral director to the following the follo | be filed within 72 hours after death with the State Dept. or result and meltial rytheric pilot to bothat, cremator, or remove. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

TO

| | FOR STATE REGISTRAR | STATE OF MA | | AND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | |
|--------------------|--|---------------------------|---|---|--------------------------------------|--------------|---------------------|-------------|--|---|------------|-------------|---------|---------------------------------|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | TE OF DEATH | | YEAR | 3. Ti | ME OF DEATH |
| | VERONICA MARGARE | T MILLS | | | | | | | | EMBER 2 | | | | 9:00 P M |
| | 4. SOCIAL SECURITY NUMBER | | . AGE (In yrs. last | birthday) | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DA | TE OF BIRTH onth, Day, Year) | | Counti | ny) | E (Stata or Foreign |
| | 219-36-5385 | 1 🗌 M 2XXF | 49 | YRS. | | | | | JA | N. 15,1 | | MAR | | AND |
| m | 9a. FACILITY NAME (If not institution, give | | | | | | | ON OF OE | ATH | | | NTY OF D | | en o |
| Ö. | 207 SUNBURST HIG | HWAY | | | CAM | BRID | GE | | | | טע | RCHE | 211 | Z.K. |
| DIRECTOR | 10a. STATE 10b. COUNT | ry . | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | | 10d. | INSIDE CITY LIMITS? |
| | MARYLAND DORG | CHESTER | | C. | AMBR: | IDGE | | | | | | | ŧΧϽ | YES 2 NO |
| ₹ I | 10e. BTREET AND NUMBER | | | | | 101 | ZIP COD | | | | 10g. CIT | | | COUNTRY? |
| FUNERAL | 207 SUNBURST HIG | | | Local | | | 1613 | | 2 | | | SA | | |
| | 11. MARITAL STATUS 1 Never Married 2 Married | | YES 2XX | YES 2XNO If yes, speci | | | | | CENDENT OF HISPANIC ORIGIN? (Specify Ya ecify Cuban, Maxican, Puarto Rican, atc.) | | | | | merican Indian, ta, atc. |
| BY | 3 Widowed 4 Divorced | IF YES, GIVE WAI | H OR DATES | ES 1 ☐ YES 2 X MO Specify: | | | | | | | | Spec | iny: | WHITE |
| COMPLETED | 15. DECEOENT'S ED (Specify only highest grad | UCATION le completed) | 16a. DEC | CEDENT'S | USUAL O work done se retired.) | CCUPATIO | ON st of workli | na | | 16b. KIND OF BUS | SINESS/INI | DUSTRY | | |
| 9 | Elementary/Secondary (0-12) | College (1-4 or 5+) | | | | | | | | TDIIO A TOT | 037 | | | |
| MP | 12 | | IEA | CHEK | 'S A | 2212 | _ | | 1 | EDUCATI | | _ | _ | |
| | 17. FATHER'S NAME (First, Middle, Last) MICHAEL HARVEY | JOSSTOK | | | | | | | | st, Middle, Maiden | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | IODDICK | 196 | . MAILING | ADDRES | S (Street a | | | | lumber, City or Tow | | | | |
| 2 | HARRY L. MILLS | | 2 | 07 S | UNBU: | RST | HIGH | WAY, | CA | MBRIDGE | , MD | 216 | 13 | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2XXCremation 3 Rec | mount from State | 20b. PLACE (| OF DISPO | SITION (N | ame of cer | netery, crer | matory or | | | CATION - | | | |
| ŀ | 4 Donation 5 Other (Specify) | | SALI: | SBUR | | | | | | | ISBU | RY, | MAI | RYLAND |
| | 21. SIGNATURE OF FUNERAL SERVICE L | ICENSEE | 22. NAME AND ADDRESS OF FAC ZELLER FUNERAL | | | | | | L H | IOME | | | | |
| | stende | LNA | ALL EAST NEW MARKET | | | | | | | | 631 | _ | | |
| | 23. PART I. Enter the diseeses, or shock, or haert fellure | complications that | ceuead the de | ead the death. Do not enter the mode of dying, such as cardiac or n aech lina. | | | | | | | Int | | | Approximate Interval Batween |
| | IMMEDIATE CAUSE (Final disease or condition | | | | | | | | | | | | - | Onset and Death |
| | resulting in death) | a. Cachexia | OR AS A CONSEC | MIENCE C | NED. | | | | | | | | | weeks |
| _ | _ | | | | • | | | | | 1 | | | | |
| 9 | Sequentially list conditions, if any, leading to immediate | b. Metastat | OR AS A CONSEC | CL NOI | na o: | r Bo | ne, | Brai | n, | Lymphat | mphatics | | | months |
| 3 | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | " Inoneral | 10 Ador | 1000 | roin | -m-s | o f. 1 1 | 113.0 | | | | | | 1 year |
| H | that initiated events regulting in death) LAST | TITO TOPE, LO. | of as a conset | MENCE | (F): | Jilla | OL 10 | ung | | | | | | 1 year |
| CERTIFICATION | | d | | | | | | | | | | | | |
| | PART II. Other significant condition | ona contributing to d | leath but not r | eculting | In the u | nderlyln | g cause | given in | Part I | , 24a. WAS AN | | 24 | | E AUTOPSY FINDINGS |
| DIC | | | | | | | | | | 1 TYES | XNO | | | IPLETION OF CAUSE DEATH? |
| ME | | | | | | | | | _ | | | | 1 [| YES 2 NO |
| PHYSICIAN: MEDICAL | 25. WAS CASE REFERRED TO MEDICAL | 1 | | | | | 100.05 | DEATH (Ch | | | | | | |
| 2 | EXAMINER? 1 YES 2 XNO | HOSPITAL: | ED/Outpetlant 2 | [] DOA | OTHE | R: | | | | Other (Specify) | | | | |
| H | 27. MANNER OF DEATH | 28a. DATE OF I | NJURY | 28b. Ttl | ME OF | 28c. IN. | JURY AT | IBBIOGRICA | _ | DESCRIBE HOW | INJURY O | CCURED | _ | |
| ВУ Р | 1 XNatural 6 Pending 2 Accident Investigation | (Month, Des | y, 10ar) | " | JURY | | YES 2 | _ NO | | | | | | |
| | 3 Suicide 6 Could not b | 26a. PLACE OF | tNJURY — At ho | me, farm, | street, fac | ctory, offic | 28 | | | LOCATION (Street City or Town, State | | er or Rural | Route | Number, |
| ETE | 4 Homicide detarmined | | | | | | | | | | | | | |
| COMPLETED | TOTAL OTHY | /SICIAN: To the best of r | | | | | | | | | | | | |
| S | one) 2 MEDICAL EXAMI | NER: On the beals of axi | amtnation and/or | Investigat | lon, in my | opinion, | death occu | ared at the | tima, | data and placa, a | nd dua to | the cause | (a) and | menner as stated. |
| BE (| 29b. SIGNATURE AND TITLE OF CERTIF | IER 40 | | | | | | ENSE NU | | | | | | nth, Day, Year) |
| 5 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CAMP | E OF DEATH OVE | D. | a Del-41 | | D | 0705 | | | | 11/2 | 4/5 | 10 |
| | | | | | | o.t- | Camb | ride. | | Md 21 | 612 | | | |
| | James F. McCarte | 32. REGISTRAF | SISTENATURE | Da | V DO | واد | cailib. | rragi | ٠, | rid., 21 | 010 | | | · |
| | NUV 3 U 190 | guna | ADMOTOR DOLL | Maria | | | | | | | | | | |



DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

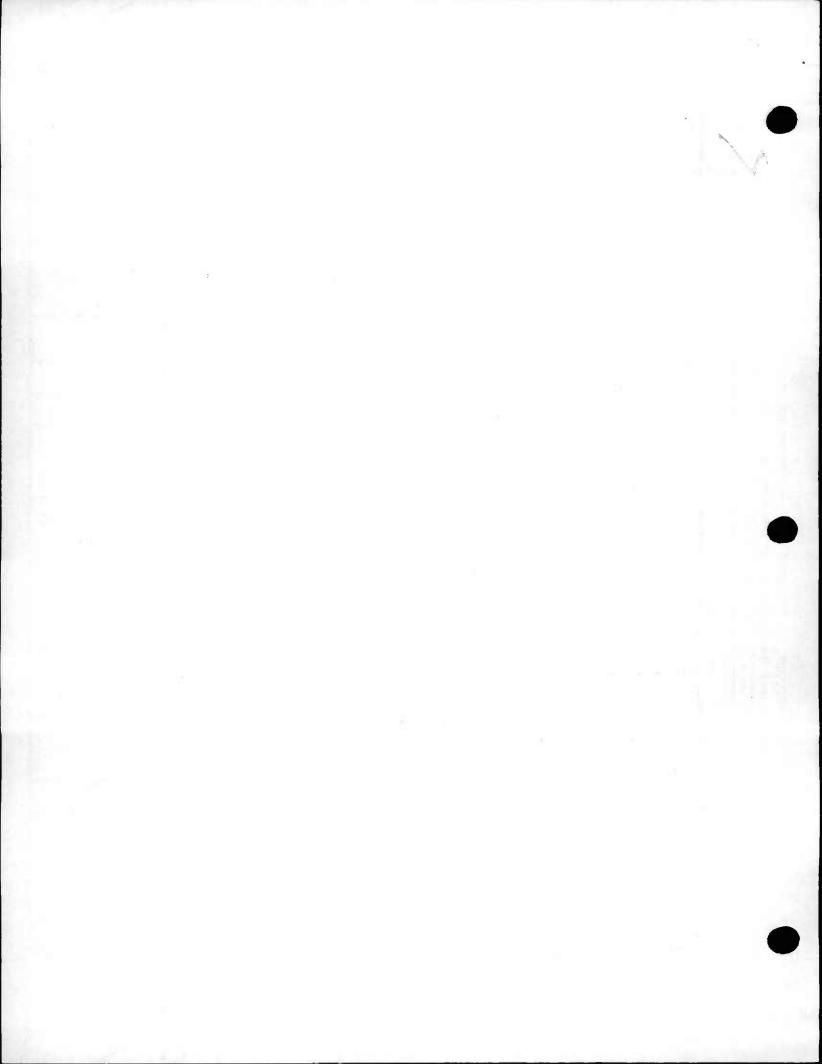
FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | 2. DATE OF | DAY | Y | EAR | TIME OF DEATH |
|---|--------------------------|--|---|--------------|---------------|--------------------|------------|---------------------------------------|-------------------------|----------------|----------------------|--|
| Manuel S. Mar | | AGE (In yrs. las | t hirthday) | IF UNDER | VEAD | IF UNDER | 94 MDS | 7. DATE OF | BIRTH | | O | ACE (State or Foreign |
| 088-147526 | 1½ M 2 🗆 F | 69 | | MONTHS | DAYS | HOURS | MIN. | | Day, Year) | | Country) | clin, N.J |
| . FACILITY NAME (If not institution, give | | - 03 | | 9b. CITY, | TOWN (| OR LOCATI | ON OF D | | -21 | 9c. COUNTY | | |
| Union Hospit | a1 | | | | | E1kt | On | | | C | eci1 | |
| TRESIDENCE OF DECEDENT | | | T 40 - 00774 | | | | JOIL | | | | | |
| Md. | | | 10c. CITY, | TOWN O | kt. | | | | | | | d. INSIDE CITY LIMITS? |
| 10e. STREET AND NUMBER | Cecil | | | | _ | . ZIP COD | E | | | ton CITIZEI | | T COUNTRY? |
| 117 W. Thomson | Drive | | | | 1.0 | . ZIF COD | 219 | 2.1 | | | | |
| 11. MARITAL STATUS | 12. WAS DECEDENT EV | | | 13. V | AS DEC | ENDENT | | NIC ORIGIN? | (Specify Yea | | U.S. | American Indien. |
| 1 Never Merried 2 Married | FORCES? 1 F | YES 2 NO NO NO NO NO NO NO NO NO NO NO NO NO | 10 | H | yes, sp | ecify Cube | ın, Mexica | en, Puerto Ric | an, etc.) | | Black, W Specify: | /hite, etc. |
| 3 Widowed 4 Divorced | | WW 2 | | | | | | , , , , , , , , , , , , , , , , , , , | | | | White |
| 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DE | CEDENT'S L We kind of wi Do NOT use | DSUAL OC | CUPATION INC. | ON ast of worki | ng | 16b. K | IND OF BUSI | NESS/INDUS | TRY | |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | 100 | | | | | | Cr | nrvsl | er Co | orp. | |
| 17. FATHER'S NAME (First, Middle, Last) | Pluc | 1 11 | rspec | ctor | | | | | | | 1- | |
| Anthony Mar | tinez | | | | | 18. MOT | | ME (First, Mid | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | OTHEZ | 191 | . MAILING | ADDRESS | (Street) | and Numba | | ilom∈ Poute Number | | | | |
| Doris William | s Martine | | | | | | | . Elk | | | | 0.1 |
| 20e. METHOD OF DISPOSITION | | 20h PLACE | OF DISPOSI | THOM /No. | | | | | | ATION City | | |
| 1 Donation 8 Other (Specify) | oval from State | other pla | Sethe | el C | eme | eter | У | | | | | ke City. |
| 21. SIGNATURE OF FUNERAL SERVICE LI | | | | 22. 1 | IAME A | ND ADDRE | SS OF FA | | 250 | | | St., |
| · dward 1 | 31-1MC/ | cows | ~ | Ge | e l | rune | ral | Hom∈ | | ton, | | 50., |
| 23. PART I. Enter the diseeses, or shock, or heart feilure. | complications that co | on each line | eth. Do no | ot enter | the mo | de of dy | ing, euc | h as cerdie | c or respir | atory arrea | t, | Approximate |
| IMMEDIATE CAUSE (Finei | | | | | | | | | | | | interval Between Onset end Death |
| disease or condition resulting in death) | · [3 | Brain | -steu | u S | X | ne | | | | | | 72. |
| | DUE TO (OR | AS A CONSECUTION AS A C | DUENCE OF |): | 1 | | | | | | | |
| Sequentielly list conditions, | b. (5 | xosi(a | al | terry | . 10 | uou | Tios | : (5 | | | | |
| if any, leeding to immediate cause. Enter UNDERLYING | DUE TO (OH | AS A CONSEC | JUENCE OF | 10. | × 6. | 00.0 | 4 | | | | | İ |
| CAUSE (Diseese or injury that initieted events | C. DUE TO (OF | AS A CONSEC | DUENCE OF | yeu): | 636 | RUU | 205 | | | | | |
| resulting in death) LAST | a . | | | | | | | | | | | |
| 24.55 | u | | Telephone III | | | | | | | | _ | <u> </u> |
| PART II. Other significent condition | | | esuiting ir | n the un | derlyin | g cause | given in | Part i. 2 | 4a. WAS AN A PERFORI | | AV | ERE AUTOPSY FINDINGS WILABLE PRIOR TO |
| Anteriosclarkic C | eaut ous es | are. | _ | | | | | — I ¹ | YES 2 | NO | | OMPLETION OF CAUSE F DEATH? |
| | | | | | | | | _ | | | 1 | YES 2 NO |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER | : | | | neck only one) | | | | |
| 1 TYES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 EF | | 28b. TIME | T . | | URY AT | esidence | 8 Other (| | JURY OCCUP | NED. | |
| 1 Natural 5 ☐ Pending | (Month, Day,) | | INJU | JRY M | WC | PRK7 YES 2 | , ' | 260. DESCI | HIBE HOW IN | JUHY OCCUP | RED | |
| 2 Accident Investigation 3 Suicide B Could not be | 28e. PLACE OF IN | JURY At ho | me, farm, at | treet, facto | | | | 28f, LOCAT | ION (Street or | nd Number or | Rural Boul | a Number |
| 4 Homicide 8 Could not be determined | building, atc. | . (Specify) | | | | | | | Town, State) | | | |
| 290. CERTIFIER 1 CERTIFYING PHYS | ICIAN: To the best of my | knowledge de | ath occurre | d at the # | ne, data | and place | and de- | to the cause | (a) and man | tar an adata d | | |
| | ER: On the besie of exam | | | | | | | | | | | nd manner as stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | _ | | ENSE NU | | | | | onth, Day, Year) |
| Edger E. Joak | in n | Gu | | | | 0 | UN | 06 | | 12 | 1 1 | 90 |
| 30. NAME AND ADDRESS OF PERSON W | O COMPLETED CAUSE | OF DEATH (ITE | W 27) (Type, | Print) | | 0.5 | | 2 | | 1 1 | 2 | |
| EDGAR E. FOLK | 374 mD | . , Uu | riont | tospi | Ho | of Ge | ci(C | a., E | -CKTO1 | v, M | | 21931 |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S | SIGNATURE | | | | | | | | | | |
| NFC 0 3 '90 | grela Davidson | -Pandal | 6 | | | | | | | | | |

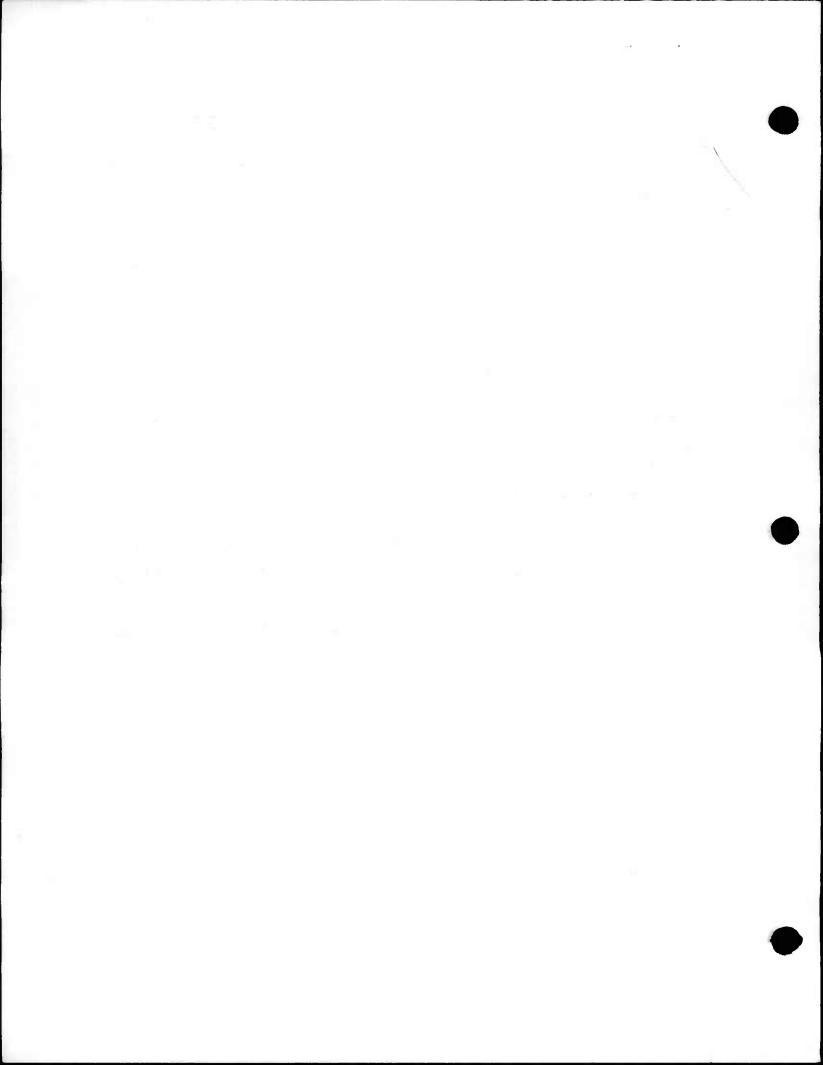
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 |
| 7 | 9 |
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| <u>S</u> | E E |
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| | | | 1 - STATE REGISTRAR | STATE OF MARY | | | | F DEATH | | GIENE G. NO. | | |
|------------|---|---------------|--|--|------------------------|------------|---|---|--|--|-----------------------------|--|
| | | | 1. DECEDENT'S NAME (First, Middle, Last) | Dorothy | M. N | lahai | n | | 2. DATE OF DE | ATH DAY | YEAR | 3. TIME OF DEATH |
| | | | | | | | | | _ | er 3, 1 | | 1315 M |
| | (P | | 4. SOCIAL SECURITY NUMBER 222-16-3933 | 5. SEX 6. AC | GE (In yrs. last 79 | YRS. | IF UNDER 1 YEA | | (Adamsh Day) | Year) | Countr | IPLACE (State or Foreign y) Tyland |
| | 1 | 1 | 9e. FACILITY NAME (If not institution, give st | | | | | VN OR LOCATION OF | DEATH | 1 | NTY OF D | EATH |
| 4: | 6, | TO | Laurelwood Nursing | ng Center | <u>.</u> | | Elkt | COII | | Ce | cil | |
| , | Pages | DIRECTOR | Marvland Cecil | | | | y, town or Lo k ton | CATION | | | 10d. INSIDE CITY LIMITS? | |
| | Ji. | 111111 | Maryland Cecil | | | ET. | T COIL | 10f, ZIP CODE | | 10g. CIT | IZEN OF V | 1 X YES 2 □ NO WHAT COUNTRY? |
| | 16 | ERA | 219 West High St | reet | | | | 21921 | | U. | S.A. | |
| 46 | aret veari. Fage o may be retained by the hospital or attending physician. by the funeral director, page 5 should be detached for use as the burial-tramit incal. Ical examiner must be notified at once. | FUNERAL | 11. MARITAL STATUS 1 X Never Married 2 Married | 12. WAS DECEDENT EVE FORCES? 1 Y IF YES, GIVE WAR OF | ES 2 X N | | If yes | DECENDENT OF HIS , specify Cuben, Mer YES 2 X NO Sp | PANIC ORIGIN? (Spe kican, Puarto Rican, ecily: | etc.) | 14, RACE Black Speci | E — American Indian, k, White, etc. |
| 3-31 | as the | ED BY | 3 Widowed 4 Divorced | | 1 | | | | | | | White |
| 21203-3146 | r use | ETE | 15. DECEDENT'S EDUC (Specify only highest grade Elementary/Secondary (0-12) | | (Gh | re kind of | USUAL OCCUP work done during se retired.) | most of working | 18b. KINO | OF BUSINESS/IN | DUSTRY | |
| 0 2 | ched fo | COMPLET | Environmenty (o-12) | 1 | Ez | kecu | tive Se | ecretary | duP | ont Com | pany | |
| MARYLAND | detach | 00 | 17. FATHER'S NAME (First, Middle, Last) | alter Maha | | | | 16. MOTHER'S | NAME (First, Middle, Rebecc | | ~~ | |
| RYL | ould be | BE | George Wa | arter mana | | MAILING | ADDRESS (Str | net and Number or Ru | ral Route Number, Cit | | | |
| MA | s 5 should notified | 임 | Sandra Anderson | | | | ugusta | | Elkton | | 2192 | 1 |
| R, | ector, page | | 20e. METHOD OF DISPOSITION 1 St Buriel 2 □ Cremetion 3 □ Rem | oval from State | 20b. PLACE C | OF DISPO | smon (Name o | cemetery, crematory | or | 20c. LOCATION - | | |
| MO | direct | | 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE \ | EIKI | con | | | facility for Fun | Elkton | | ryland |
| BALTIMORE | e funeral direction | | · Donald. | & Hickory | | | H: | icks Home ow and St ikton Mr | for Function S 21921 | erals, Streets | P.A. | |
| | d in by the or remova | | 23. PART i. Enter the diseases, or cahock, or heart failure. | | | | | | | | rrest, | Approximate interval Batwaan |
| | fion, | | IMMEDIATE CAUSE (Final disease or condition resulting in death) | Recur | Bent | - 4 | 8pisa | tion Pon | ronchopr | neuma | ula | Onset and Death |
| 13146, | executed within and completely o burial, cremati matic event, the | _ | | DUE TO (OR | AS A CONSEC | UENCE O | ,7 | tecido | ent co | | nasi | S |
| | × ~ ~ = | ATIO | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR) | AS A CONSEQ | LIENCE O | Asa. | Dis | | 20/5/ | 1/0 | 5 |
| BOX | = 5 a. | CERTIFICATION | CAUSE (Disease or Injury that initiated events | DUE TO (OR | AS A CONSEC | HUENCE O | en: | 1. | 11. 2 | 40 | () | |
| P.0 | 5 5 5 | CER | reaulting in death) LAST | e Chris | 201 | C | nga | Thre | There | Jan | i/w | - |
| RDS | 20 2 | MEDICAL | PART ii. Other algnificant condition | ns contributing to dear | th but not n | esuiting | in the under | lying cause given | | WAS AN AUTOPS! PERFORMED? YES 2 NO | 241 | a. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| | | MED | | | | | | | | , .10 1 | | 1 YES 2 NO |
| 1.1 | has been sign Dept. of Healing 23 shows | | | | | | | | | | | |
| VITAL | ficate h State C State C | <u>i</u> | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | Mutmetlant 2 | □ DO4 | | 6. PLACE OF DEATH | (Check only one) | 76.4 | | |
| OF V | YSICIAN: In s certificate th the State td, or item | PHYSICIAN: | 27. MANNER OF DEATH | 28e. DATE OF INJU (Month, Day, Ye | JRY | 28b. Til | | : INJURY AT WORK? | | E HOW INJURY O | CCURED | |
| O | DING PHYS After this death with s marked | BY | 1 Natural 5 Pending 2 Accident Investigation | | | | M 1 | YES 2 NO | | | | |
| DIVISION | TENDI OR: A fter d | ED | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJ building, etc. (| | me, farm, | street, factory, | office | 28I. LOCATION City or Tox | (Street and Numb vn, State) | er or Rurai | Route Number, |
| DIV | TO THE HOSPITAL OR AT TO THE FUNERAL DIRECT be filed within 72 hours a IMPORTANT: If Item 2 | COMPLETED | (Orlock Orly | ICIAN: To the best of my i | | | | | | | | |
| | HOSPI FUNER WITHIN | 8 | 29b. SIGNATURE AND TITLE OF CERTIFIE | ER: On the basis of examin | nation and/or i | nvestigati | on, in my opine | 29c. LICENSE | | | | D (Month, Day, Year) |
| | THE TO THE Se filed |) BE | (Jorgens) | ikalik | 1/1 | mi | | D2 | 2307 | > | 12/ | 4/90- |
| | | 5 | 30. NAME AND ADDRESS OF PERSON WA | | | | | Avenue | Elkto | on, MD | 219 | 21 |
| | | | 31. DATE FILED (Morith, Day, Year) DEC 0 4 90 | 32. REGISTRAR'S | | | | | | | | |
| V | | Щ | UEL U 4 3U | Carron | UNTRESOT - | Mander | () C. M. Co | | | · · · | | DHMH-18 Rev 1/8 |
| | | | | | | | | | | | | SHAIL 10 DOS 1/0 |
| 1 | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | |



IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| OY MARTI |
|-------------------|
| FOR STATE |
| REGISTRAR |
| 1. DECEDENT'S NA |
| 4. SOCIAL SECURIT |
| 162-01 |
| 90. FACILITY NAME |
| SALISBU |
| RESIDENCE C |
| 10e. STATE |
| MD |
| 10e. STREET AND I |
| 110A |
| 11. MARITAL STATU |
| 1 Never Merried |
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| Elementery/Sec |
| 17. FATHER'S NAME |
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| The management |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, R O Y | Middle, Last) | LEE | M | arti | | | | 2. DATE OF DEATH | | | YEAR | 3. TIME OF DEATH | | |
|------------------|--|------------------------------|------------------------|---|--|--|--------|---|---|------------|--|-----------|---|-----------------------|--|
| -) | | | | | | | | 1-10-0 DAY | 12 | | 2 | 90 | O 7:00 A M | | |
| / | 4. SOCIAL SECURITY NUMB 162-01-12 | | 5. SEX 1 🔀 M 2 🗌 F | 6. AGE (In yrs. last | | ONTHS D | AYS | HOURS MIN. | 7. DATE OF B | | 0.5 | Louisiana | | | |
| OR | 90. FACILITY NAME (If not in SALISBURY N | URSING | Service Services | | | | | R LOCATION OF DE | ATH | | | OMIC | | | |
| FUNERAL DIRECTOR | 10e. STATE | 10b. COUNT | | | 10c. CITY, 1 | | | | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 N | | |
| | MD | Wic | comico | | | Sa | | Sbury | | | 40a CITI | ZEN OF | WHAT COUNTRY? | $\stackrel{\circ}{-}$ | |
| ERA | 110A Na | ylor | | | | | 101. | 21801 | <u></u> | | log. Citi | U.S | | | |
| à | 11. MARITAL STATUS 1 Never Merried 2 3 A Widowed 4 Divo | | IF YES, GIVE V | NT EVER IN U.S. AR I A YES 2 N MAR OR DATES 1 C COTP | MED 10 | If ye | s, spe | ENDENT OF HISPAN scify Cuben, Mexica 2 NO Specify | n, Puerto Ricer | | or No— | Blec | E — Americen todler k, White, etc. Wy:White | , | |
| TED | (Specify only | EDENT'S EDU highest grade | completed) | (Gi | CEDENT'S US ive kind of wor Do NOT use i | SUAL OCCU | IPATIO | N st of working | 16b. KIN | D OF BUS | INESS/ING | DUSTRY | | | |
| COMPLETED | Elementery/Secondary (0 | 1-12) | College (1-4 or 5 | +) | Cabin | | | | 0 | wn l | Busi | nes | S | | |
| E CO | 17. FATHER'S NAME (First, M. S. A | | | Marti | n | | | 16. MOTHER'S NA | | le, Maiden | | ert | son | | |
| TO BE | 190. INFORMANT'S NAME (| | | 191 | | | | nd Number or Rural I | | | | | 1 å a b | | |
| | Lee Roy M | | 1 | 00 PI 105 | | | | ox 170 | нагі | | | | lisbury | , M | |
| | 1 Sp Buriel 2 Cremette 4 Donation 5 Other | on 3 🗆 Rem | ovat from State | other pla | | | | ,, , | | | | • | , MD | | |
| | 21. SIGNATURE OF TUNERA | | CENSEE | 0 | 700110 | Y | | ID ADDRESS OF FA | CILITY | Ja | | | | | |
| | * Deia | ld (| me | inal | | Во | un | ds Fune | ral H | ome | 705 Sal | E. | Main S ury, MD | t. | |
| | 23. PART I. Enter tha d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | aart fallure. | List only one ca | | Pa | 20 | | 200 | | | | | Approxima interval Ba Onaat and | ween | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated evants raeulting in death) LAST | | | | | | | | | | | | | | |
| MEDICAL CE | PART ii. Other algnifica | ant conditio | na contributing to | o daath but not | reaulting in | tha unde | erlyin | g cause given in | en in Part i. 24e. WAS AN AUTOPSY PERFORMEDY 1 YES 2 NO OF DEAT | | | | | NUSE | |
| 110 | | | | | | | | | | | | | | | |
| CIA | 25. WAS CASE REFERRED T EXAMINER? | TO MEDICAL | HOSPITAL: | | | OTHER: | 26. PI | ACE OF DEATH (C) | heck only one) | | | | | | |
| PHYSICIAN: | 1 TYES 2 NO | | 1 - Inpatient 2 | ☐ ER/Outpatient 3 | DOA . | 4 🗌 Nursin | | ne 5 🗆 Residence | | | | | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Netural 5 2 Accident | Pending Investigation | 28e. DATE O (Month, | Day, Year) | 28b. TIME INJU | RY M | WC | IURY AT DRK? YES 2 NO | 28d. DEŞCR | IBE HOW I | NJURY O | CCURED | | | |
| ED | 3 Suicide 6 4 Homicide | Could not be datermined | 25e. PLACE building | OF INJURY — At he g, etc. (Specify) | ome, farm, st | m, street, fectory, office 28f. LOCATION (Str. City or Town, S | | | | | Street and Number or Rural Route Number, State) | | | | |
| COMPLET | (Check only | | SICIAN: To the best of | | | | | | | | | | (e) end menner ee at | ated. | |
| TO BE (| 29b. SIGNATURE AND TITL | 146 | Trus | | | | | 29c. LICENSE NU | MBER 9 | 9 | 29d. DA | TE SIGNE | 3/9/ | | |
| | 30. NAME AND ADDRESS O | | | | | | la r | vland | 21801 | 1 | | , | / | | |
| 10 | 31. DATE FILED (Month, Dey DEC 0 4 | | 32. REGISTE | PAR'S SIGNATURE | | | ı d. L | y Lailu | 210VT | | | - | | | |
| | II DEC O 4 | - 50 | Tuna | 1 100010000-1 | williams | • | | | | | | | | | |

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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | |
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| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages | ages 1. 2.3 # |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |
| IMPORTANT: If Nem 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| | FOR | STATE OF MARYLAND | / DEDAD | TMENT OF H | EAITH AND S | MENTAL HVGIENI | . (| 90 34435 |
|--------------------|--|--|-----------------------------------|------------------------------------|--------------------------------|--|-------------------|--|
| | 1 - STATE REGISTRAR | | | CATE OF | | REG. NO. | | 0 0 0 0 0 |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| 2 | Charles . | CLIFTON | MU | LFORD | | 11 27 | 90 | 1735 M |
| | 214-10-7396 | \$EX 8. AGE (In yrs. In 87 | esi birthday) YRS. | #F UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 11-08-03 | | BIRTHPLACE (State or Foreign Country) IARYLAND |
| / | 9a. FACILITY NAME (If not institution, give street | | | 9b. CITY, TOWN O | R LOCATION OF DE | ATH | 9c. COUNTY | OF DEATH |
| PO | PENINSULA GENERAL | HOSPITAL | | SAL | ISBURY | | WICO | MICO |
| S | ©00. STATE 10b. COUNTY | | 10c. CITY | , TOWN OR LOCAT | ION | | | 10d, INSIDE CITY |
| - DIRECTOR | | OMICO | | DELMAR | | | | 1 XYES 2 NO |
| FUNERAL | 10e. STREET AND NUMBER | | | 101 | . ZIP CODE | _ | • | OF WHAT COUNTRY? |
| <u>u</u> | RAILROAD AVENUE | WAS DESCRIPTION OF THE PARTY OF | | | 2187 | | | USA |
| 5 | 11. MARITAL STATUS 12 1 Never Married 2 Married | . WAS DECEDENT EVER IN U.S. A FORCES? 1 TYPES 2 X | RMED NO | If yea, spe | ecify Cuban, Mexicar | IC ORIGIN? (Specify Yee n, Puarto Rican, atc.) | or No- 14. | RACE — American Indian, Bleck, Whita, etc. |
| A | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DATES | | 1 TYES | 2 X NO Specify | : | | Specify: White |
| | 15, DECEDENT'S EDUCATION | | ECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BUS | INESS/INDUST | TRY |
| COMPLETED | (Specify only highest grade com Elementary/Secondary (0-12) C | college (1-4 or 5+) | 'Give kind of vi fe. Do NOT us | vork done during mo e retired.) | st of working | | | |
| 7 | | | WNER | & OPERAT | OR | MEAT W | HOLESA | LE |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAI | ME (First, Middle, Malden | Surname) | |
| | JAMES (unl | k) MULFOR | .D | | ANN | (unk) | THOR | NLEY |
| BE | 19a. INFORMANT'S NAME (Type/Print) | 1 | 96. MAILING | ADDRESS (Street a | nd Number or Rural F | laute Number, City or Town | n, State, Zip Coo | de) |
| 임 | CHARLES P. MULFORI | D-SON | RT 3, | BOX 131 | , DELMAR | , MD 2187 | 5 | |
| | 20a. METHOD OF DISPOSITION 11/25 | 9/90 20b. PLAC | E OF DISPOS | SITION (Name of cen | netery, crematory or | 20c. LO | CATION — City | or Town, State |
| | 1 Donation 5 Other (Specify) | SALT | SBURY | CREMATO | RY | SAL | ISBURY | , MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | SEE | | 22. NAME AN | D ADDRESS OF FAC | DAT HOME T | ΙΑ. | |
| | Daton. il | ellowary | | | | RAL HOME, P | | MD 21801 |
| | 23. PAPT i. Enter the disesses, or com | | deeth Do s | | | RD, SALIS | | |
| | | t only ons ceues on each lie | | ot antar tha mo | us or dying, suci | r as cardiac or respi | ratory errest | Interval Between |
| | iMMEDIATE CAUSE (Fine) diseass or condition | Amtomiosol | 0700+ | in Com | 1 | los Dica | | Onset and Desth |
| | resulting in desth) s | Arterioscl | | | LIUVASCI | irar Dise | ase | |
| | _ | שטב וס (טוו אט א טטווט | LOUEITOE OI | ,. | | | | |
| CERTIFICATION | Sequentially list conditions, b | DUE TO (OR AS A CONS | EOUENCE OF | F): | | | | |
| ¥ | if sny, leading to immediate cause. Enter UNDERLYING | | | | | | | |
| 트 | CAUSE (Diseese or Injury thet Initieted events | DUE TO (OR AS A CONS | EQUENCE OF | F); | | | | |
| F | resulting in desth) LAST | | | | | | | |
| _ | CAPE II OU I III | | | | | ar a la seè a | | |
| ¥ | PART II. Other significant conditions c Chronic Obstr | cuctive Pulm | | | | Part I. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIDR TO |
| 8 | CHIOHIC ODSCI | uccive Full | onar | y Dises | 156 | 1 YES 2 | NO NO | COMPLETION OF CAUSE DF DEATH? |
| M | | | | | | | | 1 _ YES 2 _ NO |
| PHYSICIAN: MEDICAL | | | | | | | | <u> </u> |
| S | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IOSPITAL: | | OTHER: | LACE OF DEATH (Che | eck only one) | | |
| YSI | 1 XYES 2 NO | ☐ Inpetient 2 ☐ ER/Outpetient | | 4 - Nursing Horn | ne 5 🗆 Raalderica | | | |
| H | 27. MANNER OF DEATH 1 X Netural 5 Pending | (Month, Day, Year) | 28b. TIM | URY WO | PRK? | 28d. DESCRIBE HOW I | NJURY OCCUR | ED |
| B | 2 Accident Investigation | | | | YES 2 ND | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28a. PLACE OF INJURY — Al building, atc. (Specify) | home, larm, a | atreel, factory, offic | • | 261, LOCATION (Street of City or Town, State) | | Rural Route Number, |
| | | | | | | | | |
| COMPLETED | Orock only | N: To the best of my knowledge, | death occurr | ed at the time, date | and place, and dua | to the cause(a) and mer | nner an stated. | |
| 8 | one) 2 MEDICAL EXAMINER: [| On the beels of examination and/o | or investigation | on, in my opinion, c | leath occured at the | lime, data and place, an | d dua to tha c | ause(a) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIER | | | | 29c. LICENSE NUM | MBER | | IGNED (Month, Day, Year) |
| H | John 055 ul | Iseley I | eput | y M.E. | D03599 | 9 | ▶ 11 | 1-27-90 |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO C | COMPLETED CAUSE OF DEATH (IT | TEM 27) (Type | , Print) | | | | |
| - 1 | John T. Bulkele | y, M.D., 1 | 08 P. | ine Blu | ff Rd. | Salisbu | ry, N | /d., 21801 |
| つ l | | | | | | | | |
| 3 | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGNATURE | | | 20 | | | |
| 3 | | | | | | | | |

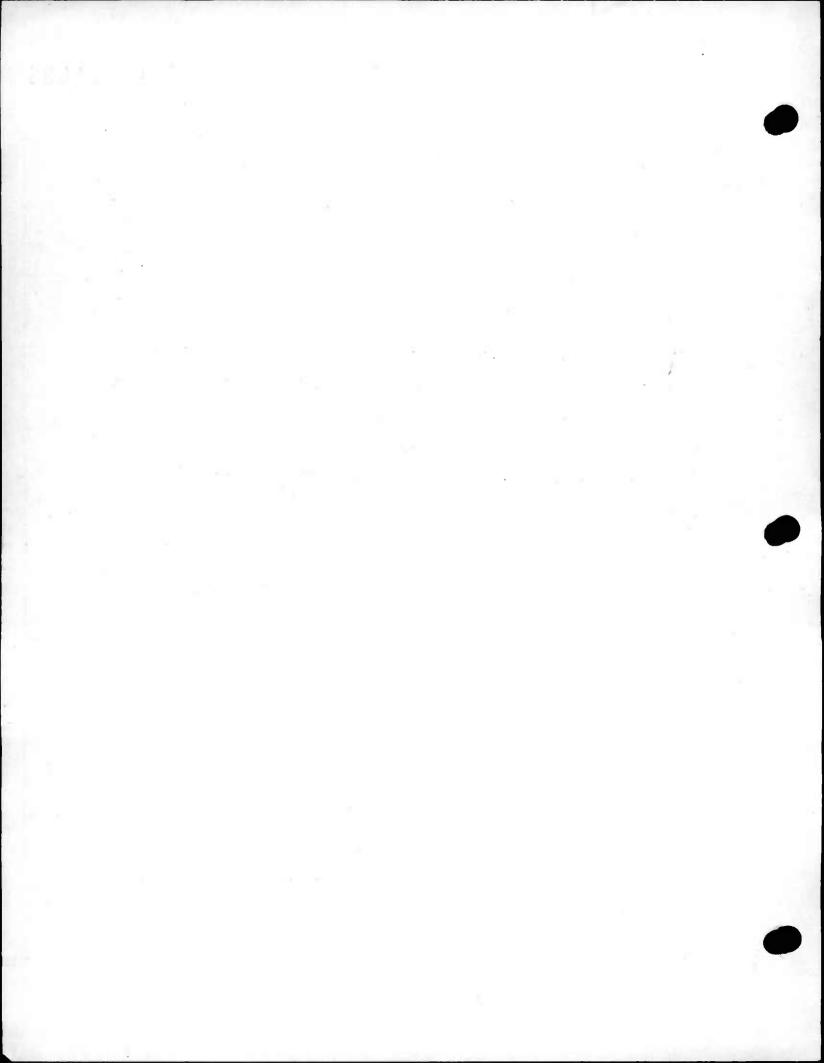
FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE 1 - STATE REGISTRAR CERTIFICATE OF DEATH REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR MOORE HARVEY LEE 11:15 A NOV. 990 6. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE OF BIRTH a. BIRTHPLACE (State or Foreign (Month, Day, Year) NOV. 20, 1934 VIRGINIA DAYS HOURS 1 X M 2 - F 56 YRS. 231-42-8365 9s. FACILITY NAME (If not institution, give street and number) 9c. COUNTY OF DEATH 9b. CITY. TOWN OR LOCATION OF DEATH DIRECTOR PENINSILLA GENERAL HOSPITAL SALISBURY, MD WICOMICO Pages 1, 2, 10b. COUNTY 10c, CITY, TOWN OR LOCATION 10a. STATE 10d. INSIDE CITY LIMITS? EXMORE NORTH HAMPTON VIRGINIA 1 YES 2 X NO permit FUNERAL 10e. STREET AND NUMBER 101, ZIP COOE 10g. CITIZEN OF WHAT COUNTRY? Page 6 may be retained by the hospital or attending physician. al director, page 5 should be detached for use as the burial-transit BOX 88, BIRDS NEST 23350 USA 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexicon, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, Whits, etc. FORCES? 1 X YES 2 IF YES, GIVE WAR OR DATES BALTIMORE, MARYLAND 21203-3146 1 Never Married 2 X Married ВУ Specify: 3 Widowed 4 Divorced AIR FORCE WHITE ETED | 15. OECEDENT'S EDUCATION 18s. DECEDENT'S USUAL OCCUPATION 18b. KIND OF BUSINESS/INDUSTRY MTION most of working (Specify only highest (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+)
2 YEARS COMPL 12 YEARS AIR FORCE MILITARY 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First Middle Maiden Sumame) MOORE BESSIE **BRADY** ISDELL **JESSIE** (unk) notified at BE 19s. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 23301 TERRY LEE AYRES-DAUGHTER ACCOMAC, VA be 20a. METHOD OF DISPOSITION 11/30/90
1 Burial 2 Coremetion 3 Removal from Str 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION - City or Town, State must funeral director. SALISBURY, MD SALISBURY CREMATORY 4 Donation 5 Other (Specify) 22. NAME AND ADDRESS OF FACILITY
HOLLOWAY FUNERAL HOME, PA examiner 21. SIGNATURE OF FUNERAL SERVICE LICENSES Hot 21801 501 SNOW HILL RD, SALISBURY, MD the . 23. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart fellure. List only one cause on each line. medical mpletely filled in by the cremation, or remove Approximate Interval Between Onset and Death IMMEDIATE CAUSE (Final the disease or condition 5mg/1611 Vad: Herentisted Carcinoma of event, resulting in death) DUE TO (OR AS A CONSEQUENCE OF): hysician and comp executed traumatic CERTIFICATION Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): the attending physician I Mental Hygiene prior to cause. Enter UNDERLYING CAUSE (Disease or injury or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST injury, PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24s. WAS AN AUTOPSY PERFORMED? 24b. WERE AUTOPSY FINDINGS law requires that the MEDICAL been signed by the AWAILABLE PRIOR TO COMPLETION OF CAUSE shows any 1 YES 2 NO OF DEATH? 1 YES 2 NO has be Dept. c PHYSICIAN: item 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF OEATH (Check only one) The certificate h HOSPITAL:

Department 2 ER/Outpatient 3 DOA OTHER: 1 TES 2 NO PHYSICIAN: 4 Nursing Home 5 Residence 8 Other (Specify) 0 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED this c is marked, 1 Natural 5 Pending Investigation м 1 YES 2 NO After t BY 2 Accident HOSPITAL OR ATTENDING 28e. PLACE OF INJURY — At home, ferm, street, fectory, office building. etc. (Specify) 281, LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 8 Could not be DIRECTOR: / COMPLETED 4 Homicide 28 Hem 29a. CERTIFIER
(Check only

1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. TO THE HOSPITAL OF TO THE FUNERAL D be filed within 72 ho 2 MEDICAL EXAMINER: On the bests of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner se stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, Day, Year) BE art 030690 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) E, Martin M.D. 145 E. Carroll St. Sclisbur 32. DEGISTRAR'S SIGNATURE
Julia Davidson-Randale

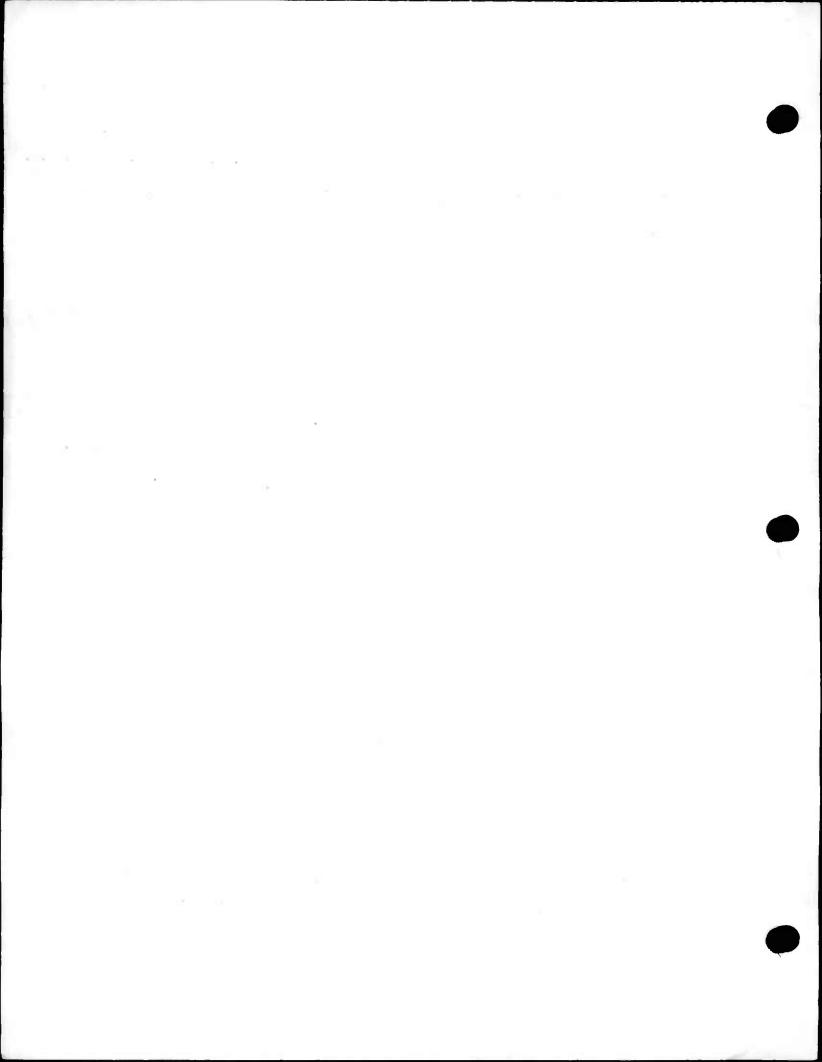
NOV 3 90

DHMH-16 Rev 1/89



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mous after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL IDIRCTOR: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 was | De hied within 72 nouns are ceath with the State Dept. Of heatht and mental hydrete prior to beneation, of removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|---|--|
|--|--|---|--|

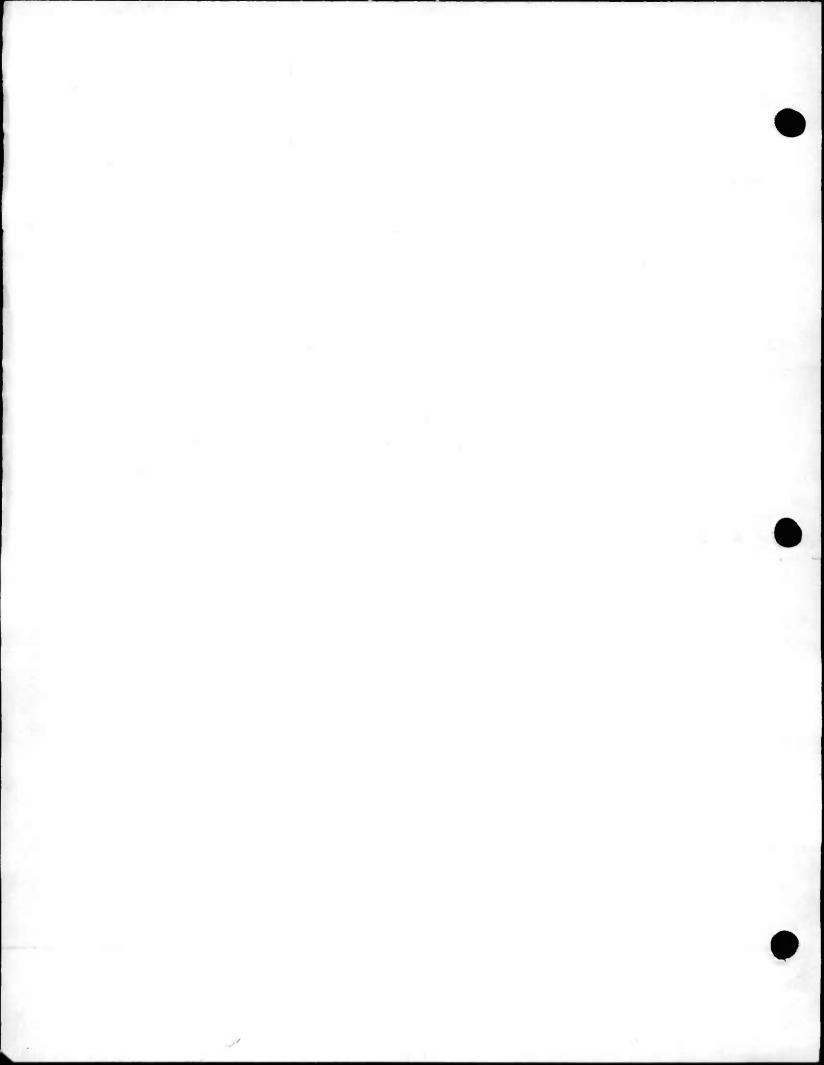
| | 1 - FOR REGISTRAR | STATE OF MARYLA | ND / DEPAR | TMENT OF H | EALTH AND I | MENTAL HYGIEN REG. NO. | - | 90 34437 | | | | |
|------------------|--|--|---------------------------|----------------------------------|--|---|---|---|--|--|--|--|
| | 1. OECEOENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH MONTH D | | 3. TIME OF OEATH | | | | | | |
| | HILDA | L MITCHELL | | | | 11/26/00 7. DATE OF BIRTH | | 1 15 AM M | | | | |
|) | 407 07 0000 | 5. SEX 6. AGE (Ir | 97s. lest birthday) 83 | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURE MIN. | DEC. 6, 1 | 906 | ST. GEORGE, S.C | | | | |
| Б | GIADYS N. SPELLMΔN. | , | TD | 96. CITY, TOWN C | PR LOCATION OF DE | ATH | | Y OF DEATH CE GEORGE | | | | |
| D. | GLADYS N. SPELLMAN RESIDENCE OF DECEDENT 108. STATE 108. COUNTY | THURS CARE | | Y, TOWN OR LOCAT | | | 11 1/11/10 | | | | | |
| L DIRECTOR | | E GEORGE | | LENARDEN | | | | 10d. INSIDE CITY LIMITS? 1 Y YES 2 NO | | | | |
| FUNERAL | 1529-7th STREET, | | | 101 | 20706 | | | N OF WHAT COUNTRY? USA | | | | |
| BY | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DAT | 2 V NO | If yes, ap- | ENDENT OF HISPAN Holfy Cuban, Maxican 2 NO Specify | IC ORIGIN? (Specify Year, Puerto Ricen, etc.) | | 4. RACE — American Indian, Black, White, etc. Specify: AFRO—AMERICAN | | | | |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade co | ATION ompleted) College (1-4 or 5+) | | | | 186. KIND OF BU | SINESS/INDUS | | | | | |
| BE CON | 17. FATHER'S NAME (First, Middle, Last) GEORGE | JOHNSON | | | 18. MOTHER'S NAI | ME (First, Middle, Maiden LANNIE | Sumame) KELLE | Υ | | | | |
| TO B | 190. INFORMANT'S NAME (Type/Print) BARBARA YATES | | | ADDRESS (Street a | | loute Number, City or Tow | n, State, Zip Co | (ode) | | | | |
| | 20e. METHOD OF DISPOSITION 1 Several 2 Comments 3 Remove 4 Donation 5 Other (Specify) | ral from State 20b. | PLACE OF DISPOS | SITION (Name of cen AEL MEMO) | setery cremetory or | 20c. LO | CATION — CH | ty or Town, State 5 ANNE, MD. | | | | |
| | 21. SIGNATURE OF TUNERAL SERVICE LICE | NSEE / | , | 22. NAME AN | ID ADDRESS OF FAC | CILITY | _ | | | | | |
| _ | Derella 2 |), folly | | | | | | 2 BOX 920 | | | | |
| | 23. PART I. ENter the diseases, or co shock, or heart fellure. Li IMMEDIATE CAUSE (Final disease or condition resulting in death) | Pres | nonic | | da of dylng, suct | n ss cardiac or reapi | retory arres | Approximate Interval Batween Onset and Death | | | | |
| CERTIFICATION | DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if sny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avents resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| | PART II. Other aignificant conditions | contributing to death by | A Isl | | | | | | | | | |
| DICAL | Cerebro Vasque | accide 2 | 1 not reaulting | in the underlying | cause given in | Part I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | | | |
| PHYSICIAN: MEDIC | Devent disc | Vlans | | | | _ | | 1 TES 2 NO | | | | |
| SIA | 25. WAS CASE REFERRED TO MEDICAL | | | 28. PL | ACE OF DEATH (Che | ck only one) | | | | | | |
| YSI | 1 🗆 YES 2 🗇 100 | HOSPITAL: 1 Inpatient 2 ER/Outpa | tient 3 🗆 DOA | OTHER: 4 Mursing Home | 5 🗆 Residence | 8 Other (Specify) | | | | | | |
| ВУ РН | 27. MANNER OF DEATH Natural 5 Pending Investigation | 28a. DATE OF INJURY (Month, Day, Year) | 28b. TIM | E OF 28c, INJ | RK? | 28d. DESCRIBE HOW I | OW INJURY OCCURED | | | | | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJURY - building, etc. (Specif | — A1 home, ferm, : (y) | street, factory, office | | 281. LOCATION (Street a City or Town, State) | net and Number or Rural Route Number, ate) | | | | | |
| COMPLETED | | AN: To the best of my knowle On the basic of examination | | | | | | ceuse(a) and manner as stated. | | | | |
| H | 29b. SIGNATURE OF CERTIFIER | Bot | N | 0 | D 400 | BER DS2 | 29d. DATE S | SIGNED (Month) Day, Year) | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO | C have | 71 | Print) | 2078 | | 0 1 | 1 | | | | |
| 0 | 31. DANOVED Meyin, (1) (bar) | 132 REGISTRAR'S SIGNA Julia Davidson-1 | | | 0 10 | | <u>.</u> | | | | | |



| 13146, |
|----------|
| ВОХ |
| P.0. |
| RECORDS, |
| OF VITAL |
| DIVISION |

| TO BE COMPLETED BY PHYSICIAN: MET | 230 SI | CHATURE AND TITLE | 111 | R | | | | | 29c. LIC | ENSE NUI | MBER CME | | | 1-20 | Aonth, Day, Year) |
|-----------------------------------|--|--|----------------------------|--|---|---------------------------------|---------------------------|----------------|---------------|--------------|--------------|---|-------------------|-----------------------|--|
| | | | 111 | | | | | - | | | - | | | | |
| PLETED | 11 (U | 1 | | | | | | | | | | | | | and manner as stated. |
| | 4 [29a. CE | Homicide | determined | CIAN: To the best o | , etc. (Specif) | | red at the | tima, data | and place | s, and due | | r Town, State) | ner as state. | 1. | |
| В | |) ALLIA | Investigation Could not be | 28a. PLACE (| OF INJURY - | - At home, farm, | street, fac | | | | | TION (Street a | nd Number o | Rural Rou | ite Number, |
| PH | 248 | Natural 5 | Pending | (Month, I | Day, Year) | 26b. TII | JURY M | | VES 2 | NO | 286. DE\$C | CRIBE HOW IN | JUHY OCCU | HED | |
| IYS | | VES 2 NO | | 1 Inpatient 2 | | | 4 🗆 Nu | rsing Hom | | asidence | 6 Other | | I II IOV OCC | DED | |
| PHYSICIAN: | EX | CASE REFERRED TO AMINER? | O MEDICAL | HOSPITAL: | | | OTHE | | ACE OF E | DEATH (Ch | eck only one |) | | | |
| N. | | | | | | | | | | | | HEAD (| ONLY | | |
| MEDIC | | | | | | | | | | | | ùXYES 2 | U NO | | F DEATH? |
| MEDICAL | PARI | ii. Other eignifice | TR CONDITION | e contributing to | OPER DUI | riot rasulting | in the u | naerlying | g cause | given in | | PERFOR | MED? | A | PERE AUTOPSY FINDING MAILABLE PRIOR TO COMPLETION OF CAUSE |
| | DADT | ii Other elemitics | nt condition | d | death had | mat assulting | in the co | a di mala da c | | eta.e. | Part I | | | I American | |
| CERTIFICATION | that li | that initiated events resulting in death) LAST | | | | | | | | | | | | | |
| CATI | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury CAUSE (Disease or Injury | | | | | | | | | | | | | | |
| ON | | entially list conditi | | b | (OR AS A C | CONSEQUENCE (| HF): | | | | | - | | | - |
| | result | ing in death) | | | | CONSEQUENCE C | | ovas | culd | u ul | sease | <u> </u> | | | 1 |
| | disea | DIATE CAUSE (Fin | | Arteri | റടറിച | rotic o | ardi | ∩1/2 C | e fun: | r di | 50350 | 2 | | | Onset and Dea |
| | 23. P/ | RT I. Enter the di shock, or he | seases, or coart failure. | complications the List only one car | it caused t use on eac | the death. Do | not anter | the mo | de of dy | ing, auci | h aa cardi | ac or respir | atory arres | it, | Approximate interval Between |
| | , | Rt. #2, Box 920, Salisbury, Md 21801 23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, Approximate | | | | | | | | | | | | | |
| 1 | 21. SIGNATURE OF PANERAL SERVICE LICENSEE (22. NAME AND ADDRESS OF FACILITY Jolley Memorial (| | | | | | | | | | | | hapel | | |
| | 1 1 B | eTHOD OF DISPOSITI Irial 2 Cremation Conation 5 COther | n 3 🗆 Reme | oval from State | phace of disposition place). een Act | es M | emo | rial l | Park | | Sali | ocation - city or town, state Lisbury, MD | | | |
| - | | nes Mapp | ION | | 201-1 | 4600 PLACE OF DISPO | | | | | , Mia | mi, Fl | | | - 00-11 |
| TO B | 19a. INI | FORMANT'S NAME (7) | | | | | | | nd Numbe | r or Rural f | Route Numbe | r. City or Town | | | |
| ш | 1 | ses M. Ma | | | | | • | | 11- | | e LeC | | ourname) | | |
| COMP | | Brd grade | iddle, Leati | | | retired- | auto | mec | | | | ervice | | n | |
| LET | | (Specify only mentary/Secondary (0 | highest grade | | +) | (Give kind of life. Do NOT u | work done se retired.) | during mo | st of working | | | | | | |
| ED B | - 5K. | 15. DECI | EDENT'S EDUC | | 1 | 6a. DECEDENT'S | USUAL O | CCUPATIO |)N | | 16b. I | KIND OF BUS | INESS/INDU: | Bla | ack |
| BY FL | | ever Married 2 [| | FORCES? | YES | 2 X NO | - 1 | If yes, spe | ecify Cubs | | n, Puerto Ri | | | Black, V Specify: | White, etc. |
| FUNERAL | | Dennis S | treet | 12. WAS DECEDEN | IT EVER IN L | J.S. ARMED | 13 | | 2180 | | NC OBIGINS | (Specify Yaa | US or No — I 1 | | - American Indian, |
| RAL | | REET AND NUMBER | | | | | | 101. | . ZIP COD | | | | | | AT COUNTRY? |
| E E | | ryland | Wicon | nico | | Sa | lisbu | rv_ | | | | | | 12 | LIMITS? |
| I W | RESI 10a. ST | | 10b. COUNTY | | | 10c. CI1 | Y, TOWN | | | | | | | | Dd. INSIDE CITY |
| CTOR | Pe | ninsula (| Genera | 1 Hospit | al | | S | alis | bury | 7 | | | Wico | mico | County |
| / | | CLITY NAME (If not in | stitution, give st | Λ. | / | 4 YAS. | 9b. CITY | , TOWN O | R LOCATI | ON OF DE | 3/11 ATH | /16 | 9c. COUNT | Virg | |
| 1/ | | S-01-4108 | ER | 5. SEX 1 ☑ M 2 ☐ F | | yrs. last birthday) 7/1 YRS. | IF UNDER | 1 YEAR DAYS | IF UNDER | 24 HRS. | | Day, Year) | 1 | . BIRTHPL Country) | ACE (State or Foreign |
|) | | 1 | Mo | ses Nat | haniel | Mar | p | | | | 11- | -19-90 | , | /EAR | 6:32PM |

DHMH-16 Rev 1/89



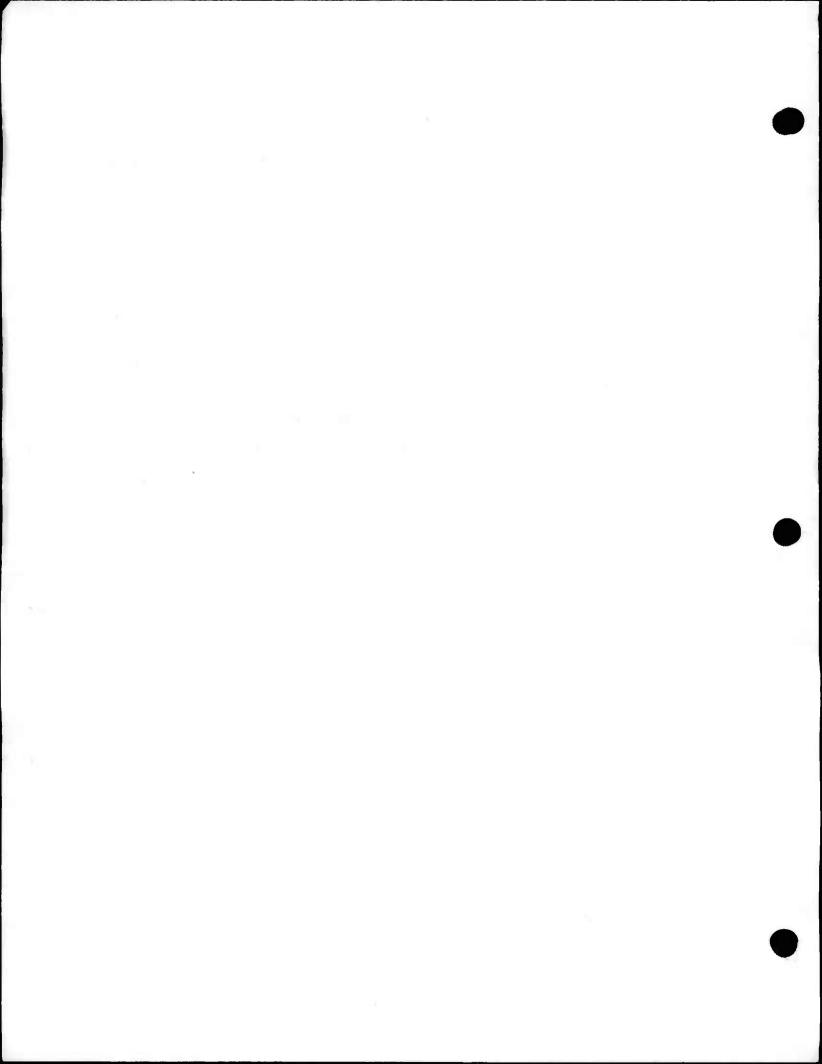
DHMH-16 Ray 1/69

1 - FOR STATE REGISTRAR

| | | 1. DECEDENT'S NAME (First, | Middle, Last) | | | š | | 4.4 | , | | 2. DATE O | F DEATH | | 3. | TIME OF DEATH |
|--|---------------|---|--------------------------|------------------------|--------------|--------------|------------------|------------------|--------------------|-------------|---------------|------------------------------|---------------|--------------|--------------------------------|
| | | OLYN | SYL | VESTER | | | 1 | Moi | rris | | NOVE | when : | | YEAR | 1420 " |
| | | 4. SOCIAL SECURITY NUME | | 5. SEX | 6. AGE (In | yrs. last bi | irthday) IF U | INDER 1 YEA | R IF UNDER | | 7. DATE OF | BIRTH | | 8. BIRTHPLA | ACE (State or Foreign |
| | | 218-05-8 | 7660 | 1)X M 2 - F | 84 | | YRS. MON | THS DAY | HOURS | MIN. | 2/1/0 | Day, Year) | | Mary | land |
| Plante | | 9a. FACILITY NAME (If not in | stitution, give a | | | | 9b. | CITY, TOW | N OR LOCATI | ON OF DE | | | 9c. COUNT | TY OF DEAT | |
| | CTOR | Peninsula G | | Hospita | 1 | | | Sal: | sbury | , MD | | | | Wicon | nico |
| es ; | [원 | 10a. STATE | 10b. COUNTY | , | | | 10c. CITY, TO | WN OR LO | CATION | | | | | 10 | d. INSIDE CITY |
| Pag | DIRE | Maryland | Wicor | nico | | | EDE | N | | | | | | 1 | LIMITS? YES 2 NO |
| ermit | | 10e. STREET AND NUMBER | | | | | 202 | <u> </u> | 10f. ZIP COD | Ε | | | 10g. CITIZ | | T COUNTRY? |
| isit p | 8 | Route #1, B | ox 322 | | | | | | | 2182 | 2 | | US | SA | |
| al-tran | FUNERAL | 11. MARITAL STATUS | | 12. WAS DECEDER | | | D | | DECENDENT (| OF HISPAN | IC ORIGIN? | | | | American Indian, hite, atc. |
| purit | | 1 Never Married 2 | | FORCES? | | | | | specify Cubi | | | ean, etc.) | - 1 | Specify: | hite, atc. |
| s the | ВУ | 3 🕅 Widowed 4 🗌 Divo | rced | | | | | | | | | | 1] | BLAC | K |
| NSe 3 | COMPLETED | 15. DEC (Specify onl | EDENT'S EDU | completed) | | (Give | kind of work | done during | | ing | 18b. F | IND OF BUS | SINESS/INDU | JSTRY | |
| Į. | <u>ا</u> و | Elementary/Secondary (6 | 1-12) | College (1-4 or 5 | +) | | o NOT use reti | red.) | | | | | | 10 | 01 |
| iched | Σ | 7th grade | | | | labo | rer | | 1 | | | | | s/Gre | en Giant |
| e detach | 응 | 17. FATHER'S NAME (First, M | | | | | | | | | ME (First, Mi | ddle, Maiden | Surname) | | |
| ad be | 씲 | Sidney Morr | | | | 100000 | | | | ne A | | | | | |
| sho Off | 2 | 19a. INFORMANT'S NAME (| | | | - 1 | MAILING ADD | | | | | - | | Code) | |
| age 5 | | Mary F. Der | | | | | #1, E | | | | Maryl | | CATION — C | | 0.4 |
| e funeral director, page 5 should al. examiner must be notified | | 1 Burial 2 Crematic | n 3 🗆 Rem | oval from State | | other place |) | , | | | | | | | |
| direc er m | | 4 ☐ Donation 8 ☐ Other 21. SIGNATURE OF FUNERA | | OTHISEE 1 | _ <u>F</u> | lowe | r Hill | 22. NAME | AND ADDRE | FISS OF FA | CHITY To | Ilov M | en, M | arylar | hanal |
| neral | | + £ 10 | 1. 1 | Ch00 | | | | | /2, Bo | | | | | | |
| ex ex | | Sauce | ua p | . your | y_ | | | | • | | | , | | | , MD |
| of in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, or removal. medical examiner must be notified at once. | | 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, euch ee cerdiec or respiratory errest, shock, or heert failure. List only one cause on each line. | | | | | | | | | | | | | Approximate interval Between |
| 00 5 | | IMMEDIATE CAUSE (FI | | | | | 1 | / | 1 | 0 | - n -A | | | | Onset and Deeth |
| completely filled ial, cremation, or event, the m | | disease or condition resulting in death) | → | · Vevi | 4 6 | inh | no b | ma | ly (| New | And | , | | | |
| mple crer | | , | | DUE TO | O (OR AS A | CONSEQU | ENCE OF): | | | | | | | | |
| anding physician and completely fille Hygiene prior to burial, cremation, or other traumatic event, the | z | Sequentially list condit | lone | b | | | | | | | | | | | |
| ian a | ΙĔΙ | if any, leeding to imme | diete | DUE TO | O (OR AS A | CONSEQU | ENCE OF): | | | | | | | | |
| physic e pric | 2 | ceuse. Enter UNDERLY CAUSE (Disease or inju | | C | O (OR AS A | CONSECU | ENCE OF | | | | | | | | - |
| ygien ygien | CERTIFICATION | that initiated events resulting in deeth) LAS | т | 500 10 | A CA 110) O | CONSECU | ENGE OF J. | | | | | | | | |
| attend ttal H | 岗 | | | d | | | | | | | | | | | 1 |
| required by the attending physician and completely filled of Heath and Mental Hygiene prior to burial, cremation, shows any injury, or other traumatic event, the | | PART II. Other significa | ent condition | | 1, | ut not res | | | | given in | Part I. | 24a. WAS AN PERFOR | | | ERE AUTOPSY FINDINGS |
| ed by | MEDICAL | Smile Di | mytra | , Osto. | with | iti | trup | lysn | m | | | 1 TYES 2 | A | C | OMPLETION OF CAUSE F DEATH? |
| Sign Heath Heath | | | | (| | (| 0 | 0 | , | | | | | | YES 2 NO |
| beer of of sh | | | | | | | | | | | | | | | |
| e has to be to the company of the Coept | SICIAN: | 25. WAS CASE REFERRED 1 EXAMINER? | O MEDICAL | | | | | | PLACE OF | DEATH (Ch | eck only one | | | | |
| rtificate h | Sic | 1 TES 2 NO | | HOSPITAL: - | ER/Outpi | ntient 3 | | THER: Nursing (| lome 5 🗆 F | Residenca | 8 🗆 Other | (Specify) | | | |
| s cer | PHY | 27. MANNER OF DEATH | | 28a. DATE O (Month, | Day, Year) | | 28b. TIME OF | 28c. | INJURY AT WORK? | | 28d. DE\$0 | RIBE HOW | NJURY OCC | URED | |
| fter this cleath with marked, | BY | .1- Netural 5 ☐ 2 ☐ Accident | Pending Investigation | , , , , | | | | M 1 | YES 2 | □ NO | | | | | |
| R. After dear is r | | 3 Suicide 8 | Could not be | | OF INJURY | | e, ferm, stree | t, factory, o | office | | | TION (Street Town, State) | and Number | or Rural Rou | te Number, |
| OR ALLEMONG PRESIDENCE. THE LAW DAY DAY DEPORTED STATE CHARLE HAS BEEN HOURS after death with the State Cept. of Item 28 is marked, or Item 23 sho | Ш | 4 Homicide | determined | | | | | | | | | | | | |
| DIRE hours | COMPLE | 29a. CERTIFIER (Check only | TIFYING PHYS | ICIAN: To the best | of my knowle | edge, dest | h occurred at | the time, | data and plac | e, and dua | to the caus | e(a) and me | nner aa state | id. | |
| FUNERAL I WITHIN 72 H | S | one) — | HCAL EXAMINI | R: On the basis of | examination | and/or Im | restigation, in | my opinio | n, death occ | ured at the | lime, data : | ind place, ar | nd dua to the | e cause(s) a | nd manner as stated. |
| FE FU | Ü | 29b. SIGNATURE AND TITL | E OF CERTIFIE | 3 1 | | | | | 29c. LIC | CENSE NU | MBER | | 29d. DATE | SIGNED (M | lonth, Pay, Year) |
| TO THE FUNER TO THE FUNER De filed within | 00 | TTY | (/ | /// | | | | | 1 | 04 | 019 | 0 | D 11 | 1/27 | 190 |
| = = = | 2 | 30. NAME AND ADDRESS C | F PERSON WI | O COMPLETED CA | USE OF DEA | ATH (ITEM | 27) (Type,) Prin | 1)) | | | 1 | 1 | 7 / | - 1 | 4.1 |
| | , , | Eddie | (/ch | 12ane | 2, M | Q _ | SA/85 | . pvi | 24 | Med | deer | 221 | CA! | NOV | xy Md |
| | 4 | NOV 28 1 | 100 100 | 32. REGISTE | | ATURE | | | , | | | | | | / { |

6

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.



TO BE COMPLETED BY FUNERAL DIRECTOR

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

26 1990

| Tennessee STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE REGISTRAR CERTIFICATE OF DEATH REG. NO. 2. DATE OF DEATH REG. NO. 2. DATE OF DEATH REG. NO. 2. DATE OF DEATH NOW I 1 - 18 - 90 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 8. AGE (In yrs. lest birthday) 81 YRS. 81 YRS. 82 YRS. 83 YRS. 84 YRS. 85 CITY, TOWN OR LOCATION OF DEATH 96. COUNTY OF DEATH |
|--|
| HOME T C. MC Intyre 11-18-90 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthdey) 81 YRS. MONTHS DAY'S HOURS MIN. (Month, Day, Year) 409-01-1111 1 VALUE OF BIRTIN (Month, Day, Year) 4-14-09 Tennessee |
| Homer C. Mc Intyre 11-18-90 4. SOCIAL SECURITY NUMBER 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. lest birthday) 81 YRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 4-14-09 1 Tennessee |
| 409-01-1111 1 VM 2 IF 81 VRS. MONTHS DAYS HOURS MIN. (Month, Day, Year) 4-14-09 Tennessee |
| 409-01-1111 1 VM 2 F 81 YRS. 4-14-09 Tennessee |
| 9e. FACILITY NAME (If not Institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH |
| |
| Knollwood Manor N.H. Millersville Anne Arundel |
| RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY |
| MD Anne Arundel Severna Park Limits? 1 □ YES 2 □ XNO |
| 106. STREET AND NUMBER 107. ZIP CODE 1004. CITIZEN OF WHAT COUNTRY? 108. ZIP CODE 11.46 109. ZIP CODE 11.46 |
| 21146 |
| 11. MARITAL STATUS 12. WAS DECEOENT EVER IN U.S. ARMED 1 Never Married 2 Merried 13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yee or No—Black, White, etc.) 14. RACE — American Indian, Black, White, etc. |
| IF YES, GIVE WAR OR DATES 1 □ YES 2 □XNO Specify: 03/06/44 11/08/45 Specify: White |
| 15. OECEOENT'S EQUICATION 18.6. DECEDENT'S USUAL OCCUPATION 18.6. KIND OF BUSINESS/INDUSTRY |
| (Specify only highest grade completed) (Give kind of work done during most of working life. Do NOT use retired.) (Cive kind of work done during most of working life. Do NOT use retired.) |
| Owned / Operated Store Variety Store |
| 17. FATHER'S NAME (First, Middle, Last) 18. MOTHER'S NAME (First, Middle, Maiden Surname) |
| Charles Mc Intyre Ella Butler |
| 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) |
| Mrs. Evelyn S. Mc Intyre 612 Park Rd. Severna Park MD 21146 |
| 20a. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of completely cremationy or 20c. LOCATION — City or Town, State |
| AXBurlel 2 Cremetion 3 Removal from State other place) A Donation 5 Other (Specify) Glen Haven Glen Burnie |
| 22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. |
| Barranco Funeral Home Severna Park MD 211. |
| my ame o |
| 23. PART J. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such ee cardiec or respiratory erreet, shock, or heert feliure. List only one cause on each line. Approximate Intervel Betw |
| IMMEDIATE CAUSE (Finel |
| disease or condition resulting in death) a. Cancer of the Colon. 500 |
| |
| DUE TO (OR AS A CONSEQUEN(DE OF): |
| Somewhile the translations (b. |
| Sequentially list conditione, if any, leading to immediate |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDI |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? 24b. WERE AUTOPSY FINDINALLABLE PRIOR TO COMPLETION OF CAUSE. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 YES 2 MO 24b. WERE AUTOPSY FINDINALIABLE PRIOR TO COMPLETION OF CAUSO OF DEATH? |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY PERFORMED? PERFORMED? 24b. WERE AUTOPSY FINDINALLABLE PRIOR TO COMPLETION OF CAUSE. |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 1. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 1. YES 2 IND 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY PRIOR TO COMPLETION OF CAUSO OF DEATH? 1 YES 2 MO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? HOSPITAL: DUE TO (OR AS A CONSEQUENCE OF): 25. PLACE OF OEATH (Check only one) |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONS |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): 24a. WAS AN AUTOPSY PERFORMED? 1 |
| Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or Injury that initiated events reculting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CON |
| Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CON |
| Sequentially list conditions, if arry, leading to immediate cause. Enter UNDERLY/INING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A |

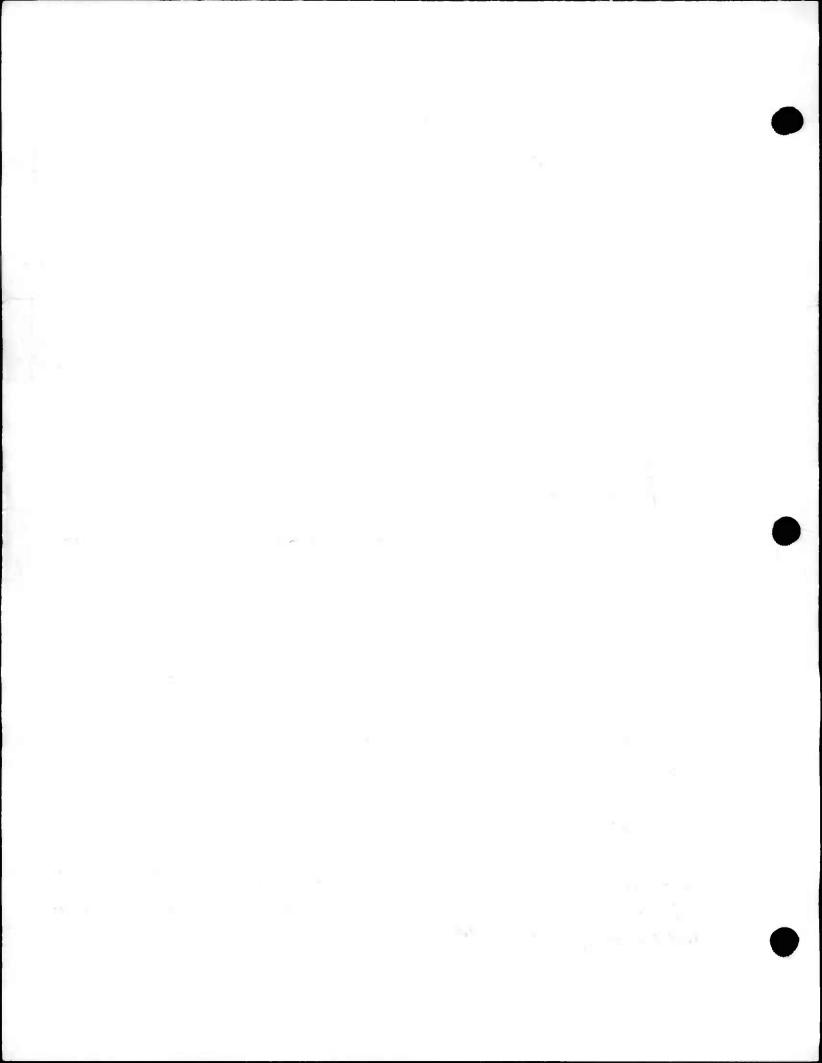
COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

MD 7R1995

32. REGISTRAR'S SIGNATURE

Park

Ave Severna

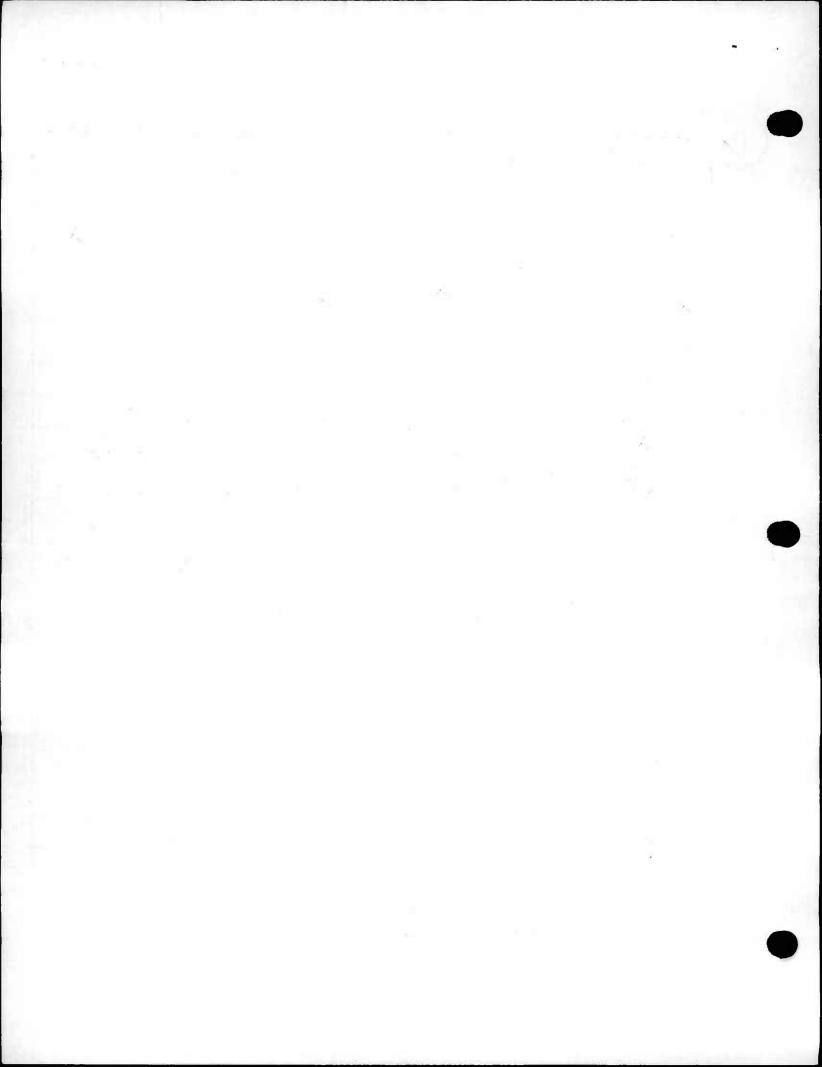


BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| | FOR 1 - STATE REGISTRAR | STATE OF MA | | PARTMEN TIFICAT | | | MEN1 | AL HYGIENE | 2 | 0 34411 |
|---------------|--|---------------------------------|---------------------------------------|------------------------------|--------------|-----------------------|--------------|--|-----------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Las | | | | | | 2. DA | TE OF DEATH | YE | 3. TIME OF OEATH |
| | DOROTHY / | | row | | | | 1: | 2 2 | 90 | 0723 AH |
| | 4. SOCIAL SECURITY NUMBER 214-01-2160 | 1 M 2 F | 5. SEX 6. AGE (in yrs. lest birthday) | | | | | | 5. E | NRTHPLACE (State or Foreign Country) |
| | 9a. FACILITY NAME (If not institution, give | | / 1 | 9b. CIT | Y, TOWN O | R LOCATION OF | | 14 1515 | 9c. COUNTY | |
| 5 | Carroll County G | ieneral Hosp | oital | V | Vestm | inster | | | Car | roll |
| DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUN | ITY | 10 | c. CITY, TOWN | OR LOCAT | ON | | | | 10d. INSIDE CITY |
| | Md. Car | roll | | Westr | ninst | er | | | | 1 YES 2 NO |
| UNEHAL | 104. STREET AND NUMBER | An+ A1 | | | 101. | ZIP CODE 2115 | 7 | | _ | OF WHAT COUNTRY? |
| NE NE | 700 Eagles Court | 12. WAS DECEDENT E | VER IN U.S. ARMED | 13 | WAS DEC | | | GIN? (Specify Yas | US. | RACE — American Indian, |
| 1 1 | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 | YES 2 NO | | | city Cuben, Mer | | | | Specify: White |
| 3 | 15. DECEDENT'S Et (Specify only highest gra | DUCATION ide completed) | (Give ki | ENT'S USUAL (| during moi | | | 16b. KIND OF BUS | INESS/INDUST | RY |
| 4 | Elementary/Secondary (0-12) 12th grade | Collegs (1-4 or 5+) | 1000000 | NOT use retired., JSEWIfe | | | | | | |
| COMPLE | 17. FATHER'S NAME (First, Middle, Last) | | 1100 | a SCHITT | | 18. MOTHER'S | NAME (Fin | st, Middle, Maiden S | Sumame) | |
| BEC | Christoptien Buc | :hler | | | | Mary I | Einma | Hatch | | |
| 2 | 198. INFORMANT'S NAME (Type/Print) Dorothy Linardi | | | | | | | ter, Md | | |
| 1 | 20a. METHOO OF DISPOSITION 1 Buriel 2 Cremation 3 Re | moval from State | 20b. PLACE OF E | DISPOSITION (A | lame of cen | etery, crematory | or | 20c. LOC | CATION — City | or Town, State |
| i | 4 □ Donation 5 □ Other (Specify) 21, SIONATURE OF FUNERAL SERVICE | | Carrol) | | | Servi D ADDRESS OF | | Ham | pstead | , Md. |
| | * Steven | W. El | ine | | | | | Eline et, Ham | | l Home , Md. 21074 |
| | 23. PART i. Enter the diseases, o shock, or heart faller | or complications that c | aused the death. | . Do not enta | r the mo | de of dying, s | uch as c | ardiac or reapir | retory arrest, | Approximate interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | Ω | 1-012 | too | м | Co | 11 | ~0 | | Onset and Death |
| ł | resulting in death) | a. DUE TO (O' | R AS A CONSEQUE | NCE OF): | + | TW | | | Α | 1716 |
| z | - SQUELLE EMPHYSEMA GYM | | | | | | | | 154M. | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| 3 | CAUSE (Disease or injury CAUSE (Disease or injury DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| ¥ | resulting in death) LAST | _ d | | | | | | | | |
| 2 | PART II. Other algolificant conditi | one contributing to de | eath but not reau | iting in the u | inderlying | cause given | in Part i | . 24a. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| 2 | | | | | | | | PERFOR | | AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? |
| MED | | | | | | | | | | 1 - YES 2 - NO |
| N. | 25. WAS CASE REFERRED TO MEDICAL | | | | 00 84 | 105 OF 651TH | | | | |
| PHYSICIAN: | EXAMINER? 1 YES 2 NO | HOSPITAL: | B/Outpatient 3 □ I | OTHE | R: | S Residen | -// | | | |
| H | 27. MANNER OF DEATH | 26s. OATE OF IN (Month, Day, | JURY 26 | Bb. TIME OF INJURY | 28c. INJ | | 7 | DESCRIBE HOW IN | JURY OCCUR | ED |
| 2 | 1 Natural 5 Pending 2 Accident Investigatio | en | | M | 1 🗆 1 | ES 2 NO | | | | |
| COMPLEIED | 3 Suicide 6 Could not be 4 Homicide determined | per building, etc | NJURY — At home, c. (Specify) | farm, street, fa | ctory, offic | | 281. | LOCATION (Street a City or Town, State) | nd Number or F | Bural Route Number, |
| 7.5 | | YSICIAN: To the best of my | y knowledge, death | occurred at the | time, date | and place, and | due to the | cause(s) and men | ner as stated. | |
| | | | mination and/or inve | etigation, in my | opinion, d | | | data and place, and | d dua to the ce | ouse(s) and manner as stated. |
| O BE | 296. SIGNATURE AND TITLE OF CERTIF | e occ | O | | | D 2 | NUMBER Q2 | 46 | P / D | GNEO (Month, Day, Year) |
| - | 30. NAME AND ADDRESS OF PERSON | WHO COMPLETED CAUSE ATPAC | OF OEATH (ITEM 27 | 7 (Type, Print) | asl | un Pt | nf | tts we | 2 toni | ister 21157 |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR | S SIGNATURE | 02 | | 0, | | | - • | |
| | DEC 3 - '90 | gulia va | Harrier Market | | | | | | | |



page 5 should be detached for

223

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OR DEATH (ITEM 27) (Type, Print)

32. REGISTRAR'S SIGNATURE

who Davidson-Randell

NARAME

SHOL

31. DATE FILED (Month, Day, Year)

'90

04

| Ď | nours after (| ed in by the | - inchiant |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after or | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burdal, cremation, or removal. | the state of the s |
| F VIIAL HECC | YSICIAN: The law requires | is certificate has been significate the State Dept. of Heal | |
| DINISION | THE HOSPITAL OR ATTENDING PH | THE FUNERAL DIRECTOR: After th filed within 72 hours after death w | |

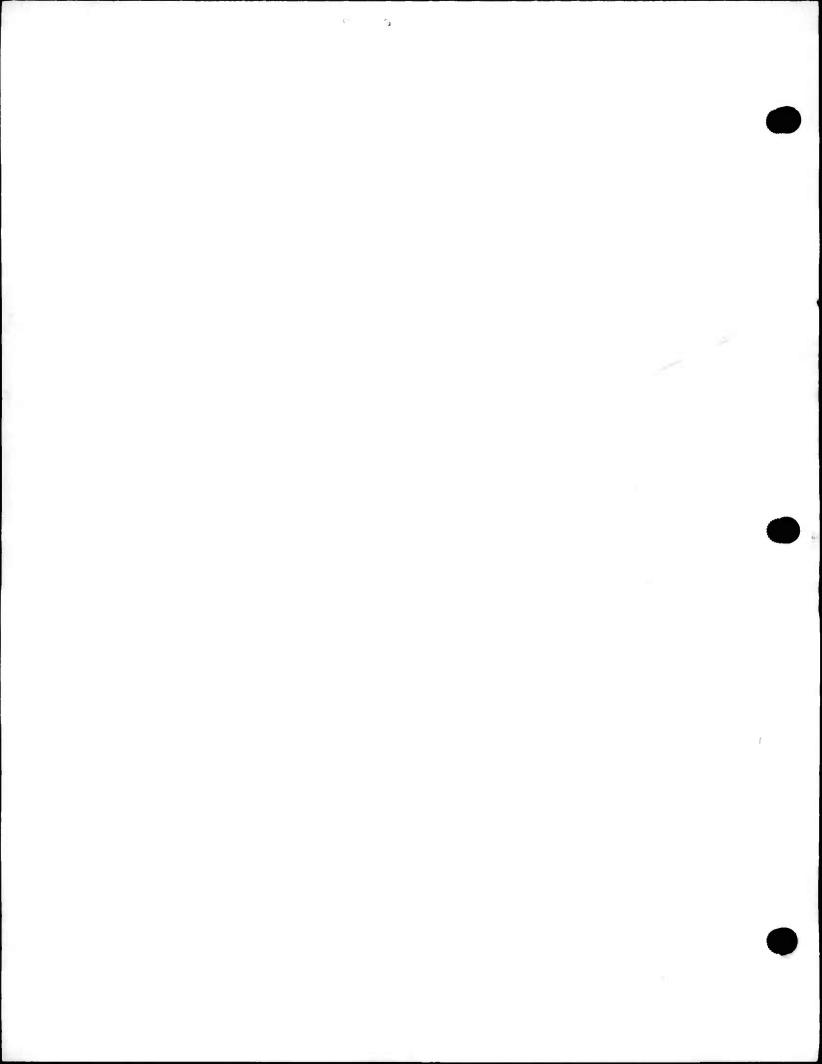
FOR STATE REGISTRAR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH YEAR Sober 11:30 Orri 2 19 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) DAYS 1 XM 2 - F 212-40-5075 50 6/2/40 Maryland 9a. FACILITY NAME (If not institution, give 9b. CITY, TOWN OR LOCATION OF GEATH 9c. COUNTY OF DEATH allston Genera allston tarford DIRECTOR RESIDENCE OF DECEDENT 10a STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY Maryland Harford Aberdeen 1 TES 2 NO 10e. STREET AND NUMBER 10g. CITIZEN OF WHAT COUNTRY? FUNERAL 10f. ZIP CODE 613 Carsins Run Road 21001 U.S.A. 12. WAS DECEDENT EVER IN U.S. ARMED 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No-11. MARITAL STATUS 14. RACE — American Indian, Black, White, etc. FORCES? 1 YES 2 NO If yes, specify Cuban, Maxican, Pu 1 ☐ YES 2 🖔 NO Specify: 1 Never Merried 2 Married Specify: ВУ 3 Widowed 4 Divorced White LETED 18e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade comp Flementary/Secondary (0-12) College (1-4 or 5 +) COMPI 10 . 0 Heavy Equip. Operator County Roads 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) Ħ Raymond Morris, Sr. BE Beulah Mousdale notified 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Diane Morris 613 Carsins Run Road, Aberdeen, MD 21001 8 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 200. METHOD OF DISPOSITION 20c. LOCATION - City or Town, State 1 X Burial 2 Cremetion 3 Ramoval from State
4 Donation 5 Other (Specify) examiner must Smith's Chapel Methodist Cem. Churchville, 21. SIGNATUREJOF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Tarring-Cargo Funeral HOme, P.A. Our Aberdeen, Md. 21001-3399 medicai 23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such se cardiec or respiratory errest, shock, or neert failure. List only one cause on each line. Approximate interval Between **Onset and Death** IMMEDIATE CAUSE (Final the disesse or condition resulting in deeth) event, traumatic CERTIFICATION Sequentially list conditions, CONSEQUENCE OF: If any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseese or injury other DUE TO (OR AS A CONSEQUENCE OF): thet initiated events resulting in death) LAST injury, or PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? shows any 1 TES 2 NO Denty 1 YES 2 NO worm PHYSICIAN: 23 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) item EXAMINER? EXAMINER? 16 OTHER: Inpatient 2 - ER/Outpatient 3 - DOA 4 ☐ Nursing Home 5 ☐ Rasidence 8 ☐ Other (Specify) e 5 27. MANNER OF DEATH 28a. DATE OF INJURY (Month, Day, Year) 28c. INJURY AT WORK? 28b. TIME OF 28d. DESCRIBE HOW INJURY OCCURED marked, Natural M 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28 Is COMPLETED 8 Could not be detarmined 4 Homicide 10 THE FUNEHAL DIRECTOR

be filed within 72 hours at

IMPORTANT: If item 2: 29s CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated. E IMEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and piece, and due to the cause(a) and manner as atlated 29b. SIGNATURE AND HILE OF O 29c. LICENSE NUMBER 29d. DATE SIGNED (Month: Day, Year) BE 9

DHMH-18 Ray t/89

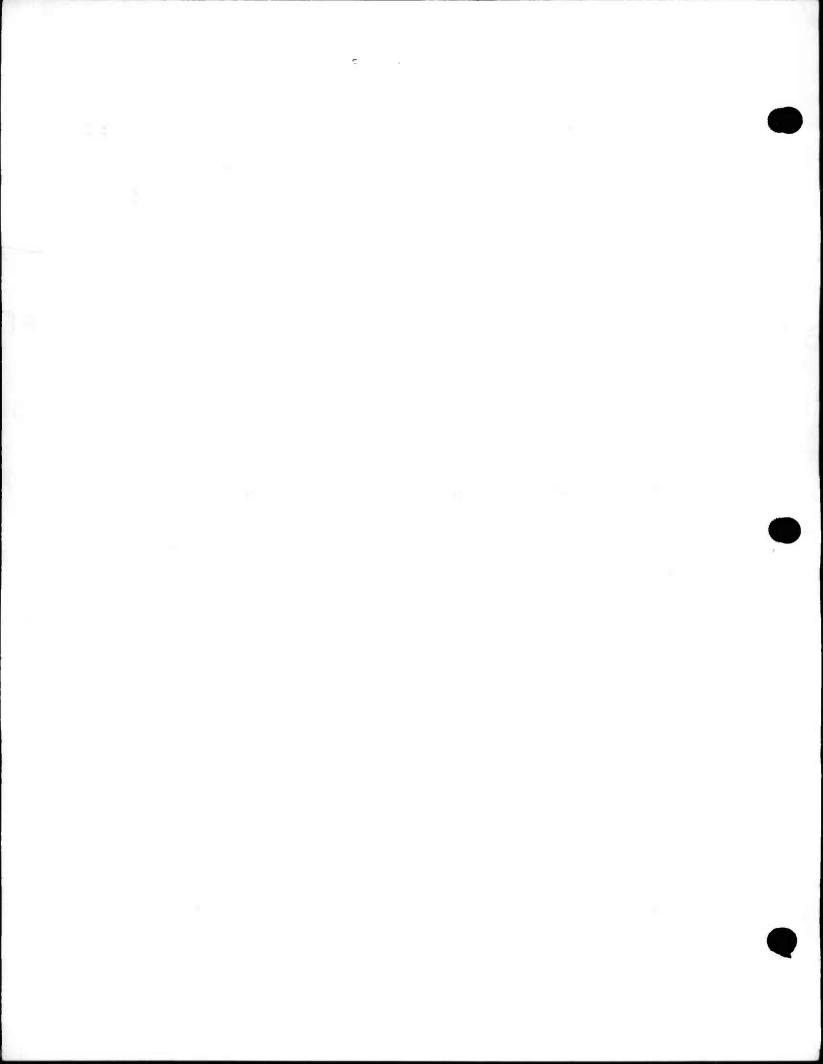
MD



| S. P.O. BOX 13146, BALLIMORE, MARTLAND | 10 THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached he filed within 72 hours after death with the State Dept, of Heatth and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13149, | TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fine within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE | 9 |
|---|---|
| CERTIFICATE OF DEATH REG. NO. | |

| | FOR STATE REGISTRAR | STATE OF MARY | LAND / DEPAR CERTIF | TMENT OF H | EALTH AND M | IENTAL HYGIEN | 9 | 0 34443 | | | | | |
|------------------------------------|--|---|---|--|--|--|---|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF OEATH | Y YE | 3. TIME OF OEATH | | | | | |
| ľ | Ree Sim | on McMillan | | | 11 25 90 | | | 9:45 P M | | | | | |
| | 4. SOCIAL SECURITY NUMBER | | E (In yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | BIRTHPLACE (State or Foreign country) | | | | | |
| | 217 - 03 - 5425 | 1 X M 2 □ F | 84 YAS. | MONTHS DAYS | HOURS MIN. | 11-17-19 | | orth Carolina | | | | | |
| | 9a. FACILITY NAME (If not institution, give st | | | 9b. CITY, TOWN O | R LOCATION OF DEA | ATH | 9c. COUNTY | OF DEATH | | | | | |
| FUNERAL DIRECTOR | Reeders Memorial | Home | | Boons | boro | | Wash | nington | | | | | |
| <u> </u> | 10e. STATE 10b. COUNTY | , | 10c. CIT | Y, TOWN OR LOCAT | ION | | | 10d. INSIDE CITY | | | | | |
| 5 | Maryland Washi | naton | Boo | nsboro | | | | 1 X YES 2 NO | | | | | |
| A | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | | | | |
| E | Route 2 Box 343 | | | | 21713 | | | U.S.A. | | | | | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT EVER FORCES? 1 YE | IN U.S. ARMED | | ENDENT OF HISPANI ocify Cuben, Mexican | C ORIGIN? (Specify Yes | or No- 14. | RACE — American Indien, Bleck, White, atc. | | | | | |
| BY F | 1 Never Merried 2 X Merried 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR | | | 2 NO Specify: | | | Specify: | | | | | |
| | | | I | | | I | | White | | | | | |
| | 15. DECEDENT'S EDUC (Specify only highest grade | completed) | (Give kind of life. Do NOT u | Work done during mos | on st of working | 16b. KIND OF BUS | SINESS/INDUST | н | | | | | |
| ٦ | Elementery/Secondery (0-12) Grade 12 | College (1-4 or 5+) | 170. | | | Self en | ل میرو ا میر | , | | | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | Carper | uei | 10 MOTHER'S NAS | AE (First, Middle, Meiden | | | | | | | |
| ö | James F. McMillan | , | | | Lulu Doi | | Garrismay | | | | | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | <u></u> | 19b. MAILING | G ADDRESS (Street e | | loute Number, City or Tow | n, State, Zip Coo | de) | | | | | |
| 임 | Arthur McMillan | | | | | ille, Penr | | | | | | | |
| | 20a, METHOD OF DISPOSITION | | Ob. PLACE OF DISPO | | | | CATION — City | | | | | | |
| | 1 🛱 Burlel 2 🗆 Cremation 3 🗆 Remi | oval trom State | Union Cer | motoru | | Ruti | tonsuil | lle. Maryland | | | | | |
| | 21. SIGNATURE OF EUNERAL SERVICE LIC | CENSEE | - 4 | 22. NAME AN | ID ADDRESS OF FAC | CILITY | | occ. martineana | | | | | |
| | DO 11.1 118 | -(1) | /. | | | reral Home | | 0 1 00 0 0 0 | | | | | |
| | 23. PART I. Enter the diseases, or | Complications that sail | ad the death. Do | | | | | Land 20707 | | | | | |
| | shock, or heart fallure. | List only one ceuse or | aech lina. | not sitter the mo | de of dying, suci | r as cardiec or reep | netory strest | interval Between | | | | | |
| | IMMEDIATE CAUSE (Final disease or condition | -1 | 0 0 | A | 0 | | | Onset and Death | | | | | |
| | resulting in deeth) | a. CWGWL | S A CONSEQUENCE O | elin ph | ulmore | y densa | ne | | | | | | |
| _ | disease or condition a. Chroni ulutrustum pulmonay dinsang DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| 5 | Sequenticity list conditions, DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| \simeq | | DUE TO (OR A | S A CONSEQUENCE O | . ,. | t feny, laeding to immediate cause. Enter UNDERLYING | | | | | | | | |
| CATIC | if eny, laeding to immediate cause. Entar UNDERLYING | DUE TO (OR A | S A CONSEQUENCE O | , ,. | | | | | | | | | |
| IFICATIO | If eny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | c | S A CONSEQUENCE (| | <u> </u> | | | | | | | | |
| ERTIFICATION | if eny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | c | | | | | | | | | | | |
| - CERTIFICATION | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | cDUE TO (OR A | S A CONSEQUENCE (| DF): | g cause given in | Part I. 24a, WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | | | | |
| A | If eny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | cDUE TO (OR A | S A CONSEQUENCE (| DF): | g cause given in | PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
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| A | if eny, laeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL | d DUE TO (OR A d ns contributing to deati HOSPITAL: 1 Inpatient 2 ER/C | S A CONSEQUENCE C | 26. PI OTHER: 4. Nursing Hon | LACE OF DEATH (Cho | PERFO 1 YES | RMED? 2 ☑ NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| PHYSICIAN: MEDICAL | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Natural 5 Pending | d | n but not reculting | 26. PI OTHER: WE OF 28c. INI ME OF 28c. INI ME OF 28c. INI ME OF 28c. INI ME OF 28c. INI ME OF WE OF | LACE OF DEATH (Chi | PERFO 1 YES seck only one) 8 Other (Specify) | RMED? 2 ☑ NO | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| BY PHYSICIAN: MEDICAL | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH Natural 5 Pending investigation | DUE TO (OR A d ns contributing to deati HOSPITAL: 1 Inpatient 2 ER/O 28e. DATE OF INJUI 28e. PLACE OF INJUI 28e. PLACE OF INJUI | but not resulting | 26. PI OTHER: 1/2 Nursing Hon ME OF 28c. IN. JUHY WC M 1 | LACE OF DEATH (Chi | PERFO 1 YES ack only one) B Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| BY PHYSICIAN: MEDICAL | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | DUE TO (OR A d ns contributing to deati HOSPITAL: 1 Inpetient 2 ER/C (Month, Day, Yes | but not resulting | 26. PI OTHER: 1/2 Nursing Hon ME OF 28c. IN. JUHY WC M 1 | LACE OF DEATH (Chi | PERFO 1 YES sck only one) 8 Other (Specify) 28d. DESCRIBE HOW | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
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| BY PHYSICIAN: MEDICAL | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Pending Investigation Pending Pending Investigation Pending Pen | DUE TO (OR A d | but not resulting butpetlent 3 DOA 28b. 7(1) JRY — At home, farm, | 26. PI OTHER: WE OF ME | LACE OF DEATH (Che 5 Residence JURY AT JURY AT YES 2 NO ce | PERFO 1 YES 3 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the cause(e) end me | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | |
| COMPLETED BY PHYSICIAN: MEDICAL | If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 2 MEDICAL EXAMINICATE) 29e. CERTIFIER (Check only 2 MEDICAL EXAMINICATE) | DUE TO (OR A d | but not resulting butpetlent 3 DOA 28b. 7(1) JRY — At home, farm, | 26. PI OTHER: WE OF ME | LACE OF DEATH (Cheme 5 Residence BURY AT PYES 2 NO | PERFO 1 YES 1 YES 2 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State) to the cause(e) end metime, date end place, e | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NED Rural Route Number, | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 MO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Pending Investigation Pending Pending Investigation Pending Pen | DUE TO (OR A d | but not resulting butpetlent 3 DOA 28b. 7(1) JRY — At home, farm, | 26. PI OTHER: WE OF ME | LACE OF DEATH (Chene 5 Residence JURY AT YES 2 NO | PERFO 1 YES 1 YES 2 Other (Specify) 3 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 5 Other (Specify) 5 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 7 Other (Specify) 7 Other (Specify) 7 Other (Specify) 8 Other (Specify) 8 Other (Specify) 8 Other (Specify) 9 Other (Spe | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NED Rural Route Number, | | | | | |
| E COMPLETED BY PHYSICIAN: MEDICAL | If eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 2 MEDICAL EXAMINICATE) 29e. CERTIFIER (Check only 2 MEDICAL EXAMINICATE) | DUE TO (OR A d ns contributing to deat HOSPITAL: 1 Inpatient 2 ER/C 28e. DATE OF INJUI (Month, Day, Yee 28e. PLACE OF INJUI building, stc. (3) | but not resulting butpetient 3 DOA av 26b. 7f in DIRY — At home, farm, specify) nowledge, death occur ation end/or investiget | 26. PI OTHER: ANUSING HOM ME OF 28c. IN. HJURY M 1 1 , street, factory, office | LACE OF DEATH (Cheme 5 Residence BURY AT PYES 2 NO | PERFO 1 YES 1 YES 2 Other (Specify) 3 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 5 Other (Specify) 5 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 7 Other (Specify) 7 Other (Specify) 7 Other (Specify) 8 Other (Specify) 8 Other (Specify) 8 Other (Specify) 9 Other (Spe | INJURY OCCUR | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NED Rural Route Number, | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR A d | but not resulting butpetient 3 DOA 37 28b. 76 18 JRY — At home, farm, poperly) DEATH (ITEM 27) (Typ. | 26. Pl OTHER: 1 In the underlying 26. Pl OTHER: 1 In Nursing Hon ME OF 1 In Nursing Hon ME | LACE OF DEATH (Chine 5 Residence JURY AT J | PERFO 1 YES 2 Other (Specify) 28d. DESCRIBE HOW 28t. LOCATION (Street City or Town, State to the cause(e) end metime, date end place, e | and Number or a stated, and due to the ci | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NED Rural Route Number, | | | | | |
| BE COMPLETED BY PHYSICIAN: MEDICAL | If eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other significent condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO (OR A d | but not resulting butpetient 3 DOA 28b. 76 B JRY At home, farm, poscify) DEATH (ITEM 27) (Typ. O Geeting | 26. Pl OTHER: 1 In the underlying 26. Pl OTHER: 1 In Nursing Hon ME OF 1 In Nursing Hon ME | LACE OF DEATH (Chine 5 Residence JURY AT J | PERFO 1 YES 1 YES 2 Other (Specify) 3 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 4 Other (Specify) 5 Other (Specify) 5 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 6 Other (Specify) 7 Other (Specify) 7 Other (Specify) 7 Other (Specify) 8 Other (Specify) 8 Other (Specify) 8 Other (Specify) 9 Other (Spe | and Number or a stated, and due to the ci | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO NED Rural Route Number, | | | | | |

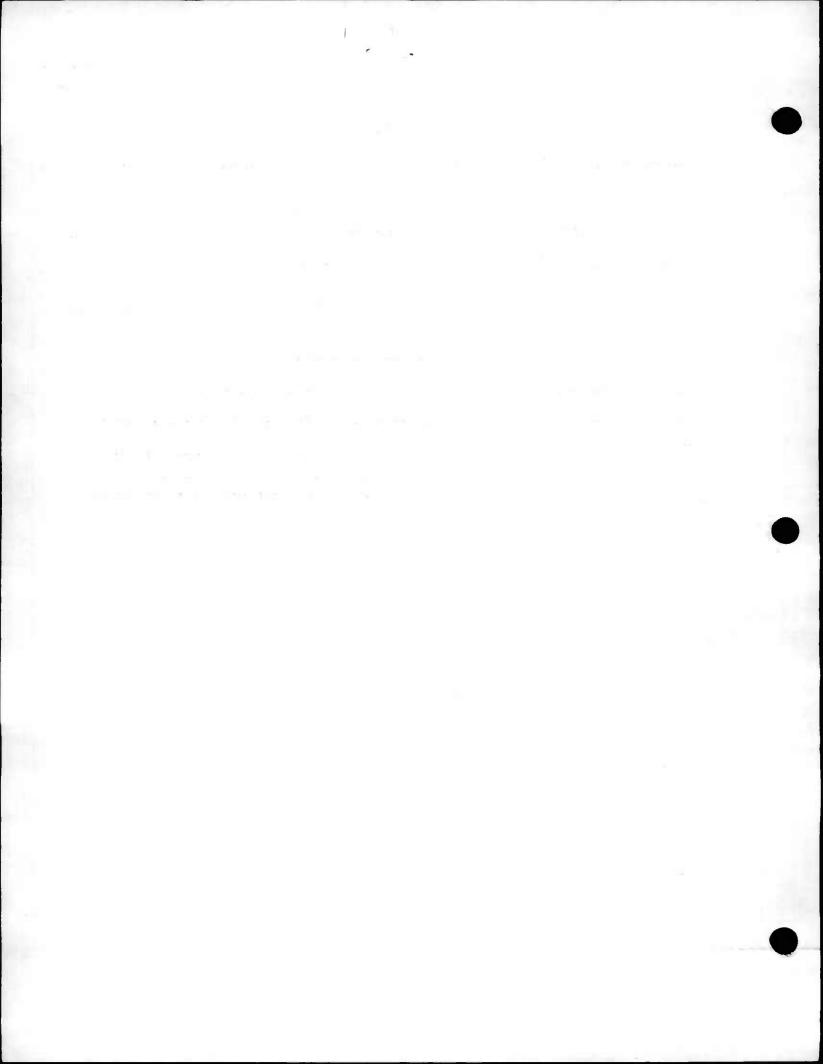


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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a four after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTION: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| 1. DECEDENT'S NAME (Firs | t, Middle, Last) | | | | | | | | 2. DATE OF DEATH MONTH DA | v | YEAR | 3. TIME OF DEATH |
|---|-------------------|--------------------|--------------------|------------------------------|-----------------------------|---|----------------|---------------|---|-----------|------------------------------|---|
| | Robe | rt A | | Miernicki | | | | | 11-24-90 PAY | | TEAR | 4:30PM |
| 4. SOCIAL SECURITY NUM | | 5. SEX | 6. AGE (In yrs. le | | | #F UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day.) (Month, Day.) (Month, Day.) (Month, Day.) | | | 6. BIRTHPLACE (State or Fore Country) | | HPLACE (State or Foreign ry) | |
| 168-34-43 | | 1 M 2 F | 46 | 46 VAS. 7/15/44 | | | | | | Pa. | | |
| 9a. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF FROSTBURG 9c. CITY, TOWN OR LOCATION OF FROSTBURG | | | | | | | EATH | | INTY OF C | | | |
| RESIDENCE OF DE | | ity Hosp | ıtal | | F | ros | stburg | 3 | | All | Allegany County | |
| 10e. STATE | 10b. COUNT | • | | | Y, TOWN O | | TION | | | | | 10d. INSIDE CITY LIMITS? |
| Pa. | Nor | thampton | | Na | zare | th | | | | | | 1 TYES 2 NO |
| 10e. STREET AND NUMBER | | | | | | 10 | H. ZIP CODE | | - | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| 535 Werkl | neiser | Avenue | | | | | 1806 | 14 | | | U | ISA |
| 11. MARITAL STATUS | 1 Married | 12. WAS DECEDER | NT EVER IN U.S. A | | | | | | NIC ORIGIN? (Specify Yearn, Puerto Rican, etc.) | or No- | 14. RAC Blac | E — American Indian, ik, White, etc. |
| 1 Never Merried 2 🔀 3 Widowed 4 Olv | | | WAR OR DATES | | | | S 2 (NO | | | | Spec | |
| 15. DE | CEDENT'S EDU | ICATION | 16a, D | ECEDENT'S | USUAL OC | CUPATI | ION | | 16b. KIND OF BU | SINESS/IN | DUSTRY | white |
| (Specify or Elementary/Secondery | nly highest grade | College (1-4 or 5 | S | Give kind of view. Do NOT us | vork done d se retired.) | luring m | ost of working | g | , | | | |
| Elementally/Secondary | (0-12) | 1 | | ec. V | ice F | res | siden | t | Bankir | 200 | | |
| 17. FATHER'S NAME (First, | Middle, Last) | | | | | | | | ME (First, Middle, Maiden | | | |
| Andrew Mi | ermick | i | | | | | Cec | elia | Zalocusky | 7 | | |
| 19e. INFORMANT'S NAME | | 77 | 1 | 9b. MAILING | ADDRESS | (Street | | | Floute Number, City or Tow | | p Code) | |
| Sandra Car | ole Mi | ernicki | | 535 W | erkhe | eise | er Av | enue | , Nazareth | ı, Pa | . 1 | 8064 |
| 20s. METHOD OF DISPOSI | TION | noval from State | 20b. PLACI | E OF DISPOS | SITION (No. | ne of ce | emetery, cren | natory or | 20c. LO | CATION - | City or To | own, State |
| 4 Donation 5 Donat | (Specify) | | Inc | dian (| | | | | | llru | n, P | a. |
| 21. SIGNATURE OF PUNER | AL SERVICE LI | CENSER | 2 | | 22.1 | NAME A | ND ADDRE | SS OF FA | cuty man Funera | 1 Ho | mee | |
| 1/0 | | 7 10 | 1. Anna | | | | | | Elkride | | | 21227 |
| Sequentially list conditions, If any, iseding to immediats cause. Enter UNDERLYING CAUSE (Disease or injury that inhibited experts our conditions). OUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | | |
| that initiated events resulting in death) LAST | | | | | | | | | | | | |
| PART II. Other signific | ant condition | ns contributing to | o death but not | resulting | in the un | dertyir | ng ceuse | given in | Part I. 24a. WAS AN | | 24 | b. WERE AUTOPSY FINDING AVAILABLE PRIOR TO |
| | | | | | | | | | 1XXYES | | | COMPLETION OF CAUSE OF DEATH? |
| XX YES 2 □ NO | | | | | | | | | | | | |
| 25 WAS CASE DEFEDRED TO MEDICAL | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? MEDICAL: 1 Inpatient 25 PLACE OF DEATH (Check only one) CTHER: 1 Inpatient 25 PLACE OF DEATH (Check only one) CTHER: 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | | | | | |
| 27. MANNER OF DEATH | | 28a. DATE O | F INJURY | 26b. TIM | E OF | 28c, IN | JURY AT | esidence | 28d. DESCRIBE HOW | INJURY O | CCURED | |
| | Pending | (Month, | Day, Year) | IN. | JURY M | W | YES 2 | NO | | | | |
| 2 Accident 3 Suicide 6 Could not be determined 4 Homicide 6 Could not be determined 26e. PLACE OF INJURY — At home, farm, street, factory, office City or Town, State) | | | | | | | er or Rurei | Route Number, | | | | |
| cont | | _ | | | | | | | to the cause(e) end ma | | | |
| XXX | | | examination and/o | r investigatio | on, in my o | pinion, | | | | nd due to | the ceuse | (e) end manner as stated |
| 296. SIGNATURE AND TITE | E OF CERTIFIE | R 1 / h | | | | | | ENSE NU | MBER | | 1-25 | D (Month, Day, Year) |
| runald) | y W. | ngm | | | | | 1 00 | ME | | | - L C | |
| DONALD V | | | USE OF DEATH (IT | | | | 0.1 | | 2.1 | | | |
| | | | AD'C CICHATUR | | T Lei | in S | stree | t,ba | altimore,MI | 212 | 201 | |
| 31. DATE FILED (Month, De | '90 | | Day John A | andell | | | | | | | | |

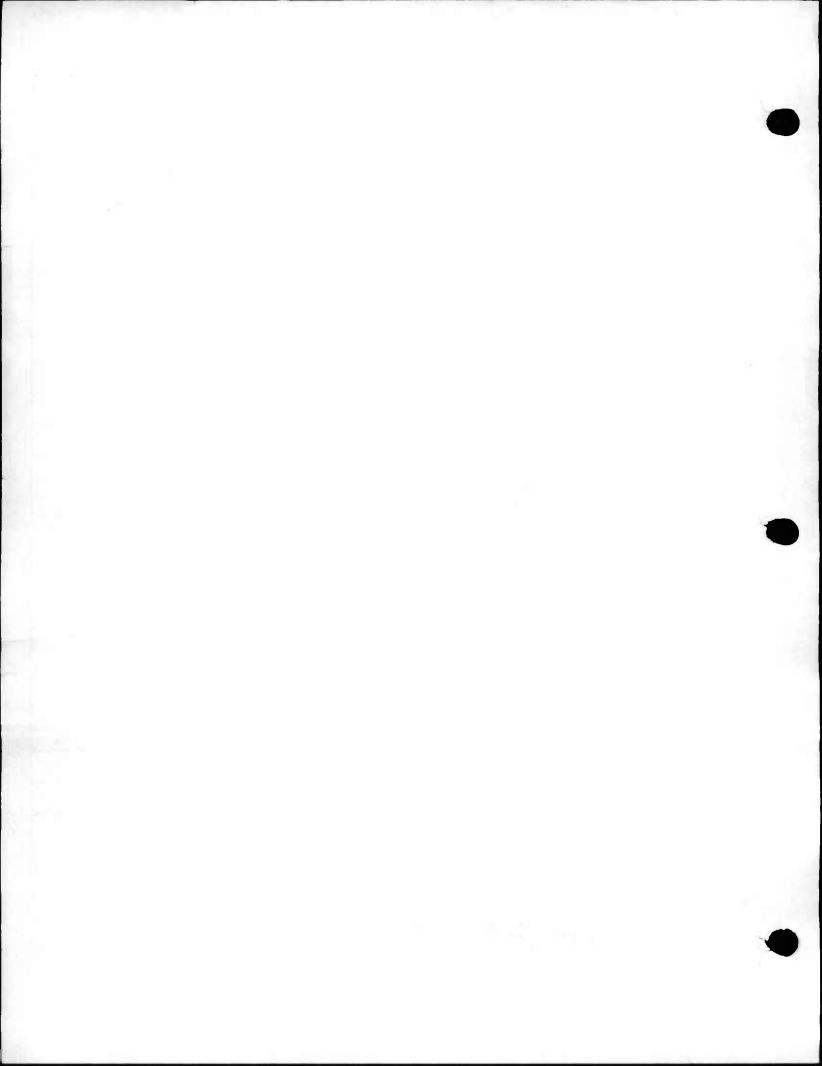


| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | BALTIMORE, MARYLAND |
|---|---|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 may rate death. Page 6 may be retained by the host | s after death. Page 6 may be retained by the hosp |
| TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | by the funeral director, page 5 should be detache |
| be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burlal, cremation, or removal. | emoval. |
| IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. | iteal examiner must be notified at once. |

31. DATE FILED (Month, Pay, Year) 1990

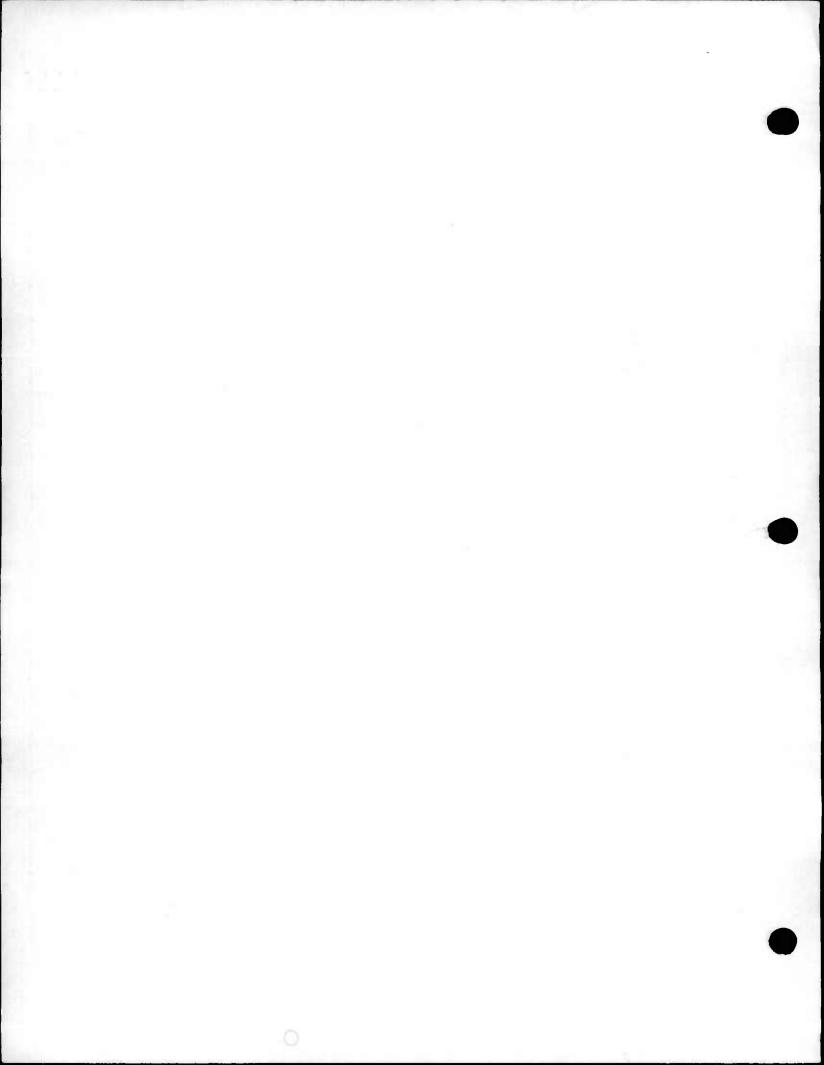
32 AEGISTRAD'S SIGNATURE PANDER

| | 1 - FOR STATE REGISTRAR | STATE OF I | MARYLAN | | | HEALTH AND | | YGIENE EG. NO. | 90 | 34445 |
|------------------------------------|--|--|---|--|--|---|---|---|---------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF D | EATH DAY | | 3. TIME OF DEATH |
| | Adonia J. Morris | sette | | | | | Dec. | 7, 1990 | YEAR | 530 AM |
| | 4. SOCIAL SECURITY NUMBER | | | | IF UNDER 1 YEAR | | 7. DATE OF B | | 8. BIRTH | HPLACE (State or Foreign |
| | 016-10-7419 | 1 → M 2 □ F | M 2 F 81 YRS. MONTHS DAYS HOURS MIN. | | | | | 3, 1909 | | ** |
| | 9a. FACILITY NAME (If not institution, give | street and number) | | | 9b. CITY, TOW | OR LOCATION OF D | | | INTY OF D | |
| DIRECTOR | 268 Fairgrounds | Road | | | Prince | Frederic | ck | Ca: | lvert | |
| ដ្ឋា | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNT | TY | | 10c, CI | TY, TOWN OR LOC | ATION | | | | 10d. INSIDE CITY |
| | Maryland Calv | ort | | | ince Fre | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | er c | - | FI. | | 10f. ZIP CODE | | 10a, CD | IZEN OF V | WHAT COUNTRY? |
| 5 | 268 Fairgrounds | Pond | | | | 20678 | | | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDEN | NT EVER IN U | I.S. ARMED | 13. WAS D | ECENDENT OF HISPA | NIC ORIGIN? (S | | 5.A. | E — American Indian, |
| | 1 Never Married 2 X Married | FORCES? | YES | 2 NO | If yes, | specify Cuben, Mexico | an, Puerto Ricar | , etc.) | Blac | k, White, atc. |
| BY | 3 Widowed 4 Divorced | | | | 1 | A LA | 7. | | | ite |
| ETED | 15. DECEDENT'S EDI (Specify only highest grad | UCATION le completed) | 10 | 6a. DECEDENT'S | Work done during | TION most of working | 16b. KIN | D OF BUSINESS/IN | DUSTRY | |
| 191 | Elementary/Secondary (0-12) | College (1-4 or 5 | | | work done during ise retired.) | | | | | |
| M M | Grade 12 | | | Police | Officer | | | Enforce | ement | |
| COMPL | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | AME (First, Middle | a, Malden Sumame) | | |
| 핆 | Joseph Morrisset | te | | - | | Nelida | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | 1 | | t and Number or Rural | | | | |
| - | Edna Hill | | | 5834 | Long Be | each Dr; S | St. Lec | nard, Ma | ary1a | ind 20685 |
| | 20e. METHOD OF DISPOSITION 1 ☐ Burtal 2 🂢 Cremation 3 ☐ Rer | moval from State | 0 | ther place) | | cemetery, crematory or | | 20c. LOCATION - | | |
| | 4 Donation * B Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE L | ICENDEE. | _ Me | tropoli | tan Cre | ematory AND ADDRESS OF FA | | Alexandı | cia, | Virginia |
| | 21. SIGNATURE OF PUNERAL SERVICE C | CENSEE | | | | | | , 4405 E | Broom | es Isl. Rd; |
| | ナン・つ | MI. | | | Port | Republic | , Mary | land 206 | 576 | |
| | 23. PART I. Enter the diseases, or ahock, or heart fallure | complications the | et caused ti | he deeth. Do | not enter the r | node of dying, suc | ch as cardlec | or respiratory a | rrest, | Approximata |
| | IMMEDIATE CAUSE (Final | . List only one ca | | | nonaro | Alrest | ~~ | | | Interval Between Onset and Death |
| | disease or condition | . < |) (1 ,1,1 | 000 | C-11 | Canca | - # | Luan | | |
| | disease or condition resulting in death) e. Squan Cell Cance of Lynn DUE TO (OFF AS A CONSEQUENCE OF): | | | | | | | | | |
| | l | DUE TO | OFAS A C | OHOLGOLINGE (|)r j. | | - 601 | | | 1 |
| N N | Sequentially list conditions | b | | | | | - 637 | | | |
| TION | Sequentially list conditions, if any, leading to immediate | b | | ONSEQUENCE (| | | | | | |
| ICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b | O (OR AS A C | ONSEQUENCE (| DF): | | | | | |
| ITIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | b | O (OR AS A C | | DF): | | | | | |
| CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury | b | O (OR AS A C | ONSEQUENCE (| DF): | | | | | |
| AL CERTIFICATION | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | O (OR AS A CO | ONSEQUENCE (| DF): In the underly | ing cause given in | Part I. 24e | . WAS AN AUTOPSY | 248 | b. WERE AUTOPSY FINDINGS |
| SAL SAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | O (OR AS A CO | ONSEQUENCE (| DF): In the underly | ing cause given in | | PERFORMED? | 248 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| SAL SAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | O (OR AS A CO | ONSEQUENCE (| DF): In the underly | ing cause given in | | | 248 | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | b | O (OR AS A CO | ONSEQUENCE (| DF): In the underly | ing cause given in | | PERFORMED? | 241 | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST PART II. Other algnificant condition ATTURNOCOL | b. DUE TO c. DUE TO d | O (OR AS A CO | ONSEQUENCE (| In the underly | ing cause given in | 1(| PERFORMED? | 246 | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant conditions the conditions of the conditions of the conditions of the cause of the caus | b | O (OR AS A CO | ONSEQUENCE CONSEQU | In the underly 26. OTHER: | ing cause given in | 1 (| PERFORMED? YES 2 NO | 241 | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition ATT CONTROL CAUSE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | b. DUE TO c. DUE TO d | O (OR AS A CO | ONSEQUENCE CONSEQU | In the underly 28. OTHER: 4 □ Nursing H | PLACE OF DEATH (C) | 1 (| PERFORMED? YES 2 NO | | AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other aignificant condition ATL COST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Natural 6 Pending | b. DUE TO c. DUE TO d | O (OR AS A CO | ONSEQUENCE CONSEQU | In the underly 26. OTHER: 4 □ Nursing H ME OF 28c. | Ing cause given in | 1 (| PERFORMED? YES 2 NO | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Natural 6 Pending Investigation 3 Suicide 6 Could not be | b. DUE TO c. DUE TO d. DOIS CONTRIBUTING TO HOSPITAL: 1 Inpetient 2 26e. DATE 0 (Month, inc.) | O (OR AS A CO O | onsequence of on | In the underly 26. OTHER: 4 □ Nursing H ME OF 28c. | PLACE OF DEATH (C) Ome 5 Residence NJURY AT WORK? YES 2 NO | heck only one) 6 Other (Sp 28d, DESCRIII 28f, LOCATIO | PERFORMED? YES 2 NO | CCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant condition ATL COST 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 100 27. MANNER OF DEATH 1 Netural 6 Pending Investigation | b. DUE TO c. DUE TO d. DOIS CONTRIBUTING TO HOSPITAL: 1 Inpetient 2 26e. DATE 0 (Month, inc.) | O (OR AS A CO O (OR AS A CO O death but Coo of ER/Outpatt F INJURY Ony, Year) | onsequence of on | In the underly 26. OTHER: 4 Nursing H MURL M | PLACE OF DEATH (C) Ome 5 Residence NJURY AT WORK? YES 2 NO | heck only one) 6 Other (Sp 28d, DESCRIII 28f, LOCATIO | PERFORMED? YES 2 NO ecity) BE HOW INJURY OF | CCURED | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 ON 27. MANNER OF DEATH 1 Natural 6 Pending Investigation 29 Accident Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only 1 CERTIFYING PHY: | DUE TO | O (OR AS A CO O | onsequence of on | In the underly 28. OTHER: 4 Nursing H ME OF 28c. JURY M 1 street, factory, of | PLACE OF DEATH (C) Ome 5 Residence NJURY AT WORK? YES 2 NO | 1 (Check only one) 6 (Check Only one) 28d. DESCRIII 28f. LOCATIO City or 70 | PERFORMED? YES 2 NO ecity) BE HOW INJURY OF North Control of Number 1 (Street and Number 1), State) | CCURED or or Rural | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO C. DUE TO d. HOSPITAL: 1 Inpatient 2 26a. DATE Duliding 28b. PLACE building | O (OR AS A CO O | onsequence of on | 26. OTHER: 4 Nursing H ME OF 28c. JURY M 1 street, factory, of | PLACE OF DEATH (C) ome \$ Reeldence NUURY AT WORK? YES 2 NO | 1 Check only one) 6 Other (Sp 28d. DESCRIII 28f. LOCATIO City or 70 | PERFORMED? YES 2 NO ecity) BE HOW INJURY Or N (Street and Numb wm, State) | CCURED or or Flural ated. | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | If any, leading to immediate cause. Enter UNDERLYING CAUSE. (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | DUE TO C. DUE TO d. | O (OR AS A CO O | onsequence of on | 26. OTHER: 4 Nursing H ME OF 28c. JURY M 1 street, factory, of | PLACE OF DEATH (C) ome \$ Reeldence NUURY AT WORK? YES 2 NO | 1 (Control one) 6 Other (Sp. 28d. DESCRII 28f. LOCATIOn City or 70 e to the cause(e a time, date and | PERFORMED? YES 2 NO ecily) BE HOW INJURY Or N (Street and Numb wm, State) and manner as st place, and due to | or or flural sted. | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATHY 1 YES 2 NO Route Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 200 27. MANNER OF DEATH 1 Netural 6 Pending Investigation 3 Suicide 6 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | DUE TO C. DUE TO d. | O (OR AS A CO O | onsequence of on | 26. OTHER: 4 Nursing H ME OF 28c. JURY M 1 street, factory, of | PLACE OF DEATH (C) ome 5 Residence NJURY AT WORK? YES 2 NO | 1 (Control one) 6 Other (Sp. 28d. DESCRII 28f. LOCATIOn City or 70 e to the cause(e a time, date and | PERFORMED? YES 2 NO ecily) BE HOW INJURY Or N (Street and Numb wm, State) and manner as st place, and due to | or or flural sted. | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, |
| COMPLETED BY PHYSICIAN: MEDICAL | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 200 27. MANNER OF DEATH 1 Netural 6 Pending Investigation 3 Suicide 6 Could not be determined 29. CERTIFIER (Check only one) 2 MEDICAL EXAMIN | DUE TO C. DUE TO d. | D (OR AS A CO D | onsequence of on | In the underly 28. OTHER: 4 Nursing H WINDERLY M 1 Street, factory, of red at the time, d ion, in my opinior | PLACE OF DEATH (C) ome 5 Residence NJURY AT WORK? YES 2 NO | S Other (Sp 28d, DESCRII 28f, LOCATIO City or 76 a time, date and | PERFORMED? YES 2 NO ecily) BE HOW INJURY Or N (Street and Numb wm, State) and manner as st place, and due to | or or flural sted. | AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, |



| BALTIMORE, MARYLAND 21203-3146 | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within wours after death. Page 6 may be retained by the hospital or attending physic | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|--|
| 13146, | executed within . | and completely for burial, cremation | natic event, th |
| P.O. BOX | ath certificate be | tending physician al Hyglene prior t | or other traur |
| RECORDS, | requires that the de- | en signed by the all of Health and Ment | shows any injury |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | PHYSICIAN: The law | this certificate has by with the State Dept. | ked, or item 23 |
| DIVISION | HOSPITAL DR ATTENDING F | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fi be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | TANT: If Item 28 is mar |
| | TO THE ! | De filed w | IMPORT |

| | 1 - STATE REGISTRAR | SIAIE UF I | | | ICATE OF | | | | EG. NO. | 5 | | 0 0999 |
|------------------|---|----------------------|---------------------|---------------|--|-----------------------|------------|-------------------|-------------------------|---------------|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | 2. DATE OF D | EATH DA | | YEAR | 3. TIME OF DEATH |
| | Lucie Er | ngelharth | ŀ | McG | eeney | | | Dec | | 199 | | 1425 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | | IF UNDER 1 YEAR | IF UNDER | | 7. DATE OF B | | | 6. BIRTH Countr | PLACE (State or Foreign |
| | 080 16 4021 | 1 M 2 X F | 69 | YRS. | MONTHS DAYS | HOURS | MIN. | 10-31 | | | Nor | |
| | 9e. FACILITY NAME (If not institution, give a | treet and number) | | | 9b. CITY, TOWN | OR LOCATI | ON OF DE | ATH | | 9c. COU | NTY OF D | EATH |
| S S | Calvert Memor | cial Ho | spital | | Prin | ce F | rede | erick | | Ca | lver | ct |
| 디 | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | | - | 10c. CIT | Y, TOWN OR LOC | | | | | | I | 10d, INSIDE CITY |
| <u>E</u> | MD Cal | rert | | | kirk | | | | | | | LIMITS? |
| ار | 10e. STREET AND NUMBER | | | | T | Of, ZIP COD | E | | | 10g. CIT | ZEN OF W | WHAT COUNTRY? |
| FUNERAL DIRECTOR | 2810 Chesapeake | Beach Ro | ad | | | 20754 | | | | | SA | |
| 3 | 11. MARITAL STATUS | | IT EVER IN U.S. AF | | | | | IC ORIGIN? (Sp | | or No- | 14. RACE | American Indian, |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 X | Ю | | specify Cubi | | , Puerto Rican | , etc.) | | | t, White, etc. |
| BY | 3 🔀 Widowed 4 🗌 Divorced | | | | | | | | | | whi | te |
| COMPLETED | 15. OECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a, D6 | CEDENT'S | USUAL OCCUPATION of the control of t | TION nost of world | ng | 16b. KIN | D OF BUS | BINESS/IND | DUSTRY | |
| Ë | Elementary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | ,, | C D- | -4-1 | 0 | |
| ₹ I | 10 | | I | nall | carrier | _ | | | | stal | Ser | vice |
| 8 | Henry Michael Lu | nd | | | | 110-47-1 | dega. | ME (First, Middle | a <i>Maiden</i> Orth | | Ber | ~ |
| H | 19a. INFORMANT'S NAME (Type/Print) | | | b. 54419 1814 | AOORESS (Stree | | | | | | | 9 |
| 2 | Lisa Zobrisky | | | | as 10 | | | toute Number, C | aty or low | n, State, Zij | Code) | |
| | 20e. METHOD OF DISPOSITION | | 20h PLACE | | SITION (Name of c | _ | | | 20c I O | CATION — | City or To | wa State |
| | 1 Burial 2 C Cremation 3 Rem 4 Donation 5 Other (Specify) | oval from State | other p | lace) | tan Cre | | | | | xand | | |
| | 21. SIGNATURE OF FUNERAL SERVICE U | CENSEE | 11 | | | AND ADDRE | - | CILITY | | | | |
| | M/ 11.1 | 1 04 | 9 | | | | _ | | | | | |
| - | ///. // //Cra | 9 1 19 | 5/200 | | | | | ral Ho | | | - | MD 20736 |
| | 23. PART I. Enter the diseases, or ahock, or haert fallure. | List only one car | use on each line | a. | not enter the n | lode of dy | Ing, suct | n aa cerdiac | or reap | ratory an | reat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Final disease or condition | 0- | 11-5 | | | | | | 1 | | | Onset and Death |
| | resulting in desth) | LOV | TOTAL A CONSE | MALL | wnov | 2 | | irres | 1 | | | |
| | | | | - | | | 1 | | | / | | 9 |
| S S | Sequantially list conditions, | b. DUE TO | SP 82 | OUENCE O |) //) | ery, | neu | cery | -/ | | | 2 weeks |
| ¥ | if any, leading to immediate couse. Enter UNDERLYING | | Mous | | | <u> </u> | P | nomo | 701 | ā. | | Jahren . |
| 필 | CAUSE (Disease or Injury that initiated events | DUE TO | (OR AS A CONSE | OUENCE C | F): | ,,,,,,, | , , , | , 40/170 | 70 7 6 | | | |
| CERTIFICATION | resulting in death) LAST | d | | | | | | | | | | |
| 2 | PART II. Other algnificant condition | se contribution to | double but not | | la the variety | | | Don't at | | AUTOPSY | Lan | |
| DICAL | Cerebrovona | | | | - | ing cause | given in | | PERFOR | MED? | 240 | AMAILABLE PRIOR TO COMPLETION OF CAUSE |
| ă | 10 1 1 0 | | | A | | D. | 0.1.00.0 | 10 | YES 2 | NO | | OF DEATH? |
| ž | Rt hemigel | egra. | 150 | uao | monas | _ n | eumo | ma | | | | 1 - YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | U | _ | | | DI 105 05 5 | F 1711 001 | | | | | |
| PHYSICIAN: MEI | EXAMINER? | HOSPITAL: | | | OTHER: | | | eck only one) | | | - | |
| ¥ | 27. MANNER OF DEATH | 28a. DATE O | ☐ ER/Outpatient : | 28b. Til | 4 Nursing H | NJURY AT | esidence | 28d. DESCRII | | NJURY OC | CURED | |
| | 1 Natural 5 Pending | (Month, I | Day, Year) | IN | JURY 1 | VORK? | ¬ NO | | | | OUTLE | |
| BY | 2 Accident Investigation 3 Suicide & Could not be | 26e. PLACE | OF INJURY — At h | ome, farm, | | | _ | 261. LOCATIO | N (Street | end Numbe | r or Rural I | Route Number, |
| | 4 Homicide 6 Could not be datermined | building | , etc. (Specify) | | | | | City or To | wn, State) | 1: | | |
| ۳ | 29a. CERTIFIER 1 X CERTIFYING PHYS | ICIAN: To the best o | f my knowledge d | eath occur | red at the time of | de and plac | and this | to the equation |) and ma | nnes ne etc | da.d | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMIN | | | | | | | | | | | e) and manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | _ | ENSE NUN | | | | | (Month, Day, Year) |
| 8 | Lahn | Jons | amy | | | D | | 189 | | | | 6.90. |
| 2 | 30. NAME AND ADDRESS OF PERSON WI | 10 COMPLETEO CAL | ISE OF DEATH (ITI | | | | | , | _ | | | 152 |
| | Z Yousaf, | M.D. | | Pri | nce Fr | deri | ck, | Mary. | land | 02 | 678 | |
| | | | | | | | | | | | | |
| | 31. DATE FILED (Morth, Dey, Year) DEC 0 7 199 | 32. DEGISTR | AR'S SIGNATURE | 2 8 64 | , | | | | | | | |



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| BALTIMORE, MARYLAND 21203-3146 | TO THE MICHAEL PRYSICIAN: The law requires that the death certificate be executed within A mount after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pa be filled within 72 hours after death with the State Dept, of Health and Mental Hypiene prior to burial, cremation, or removal. | |
| 13146, | recuted within | ind completely burial, crematic | |
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| DS, P.O. | it the death ce | by the atten | |
| ECORDS, P.O. | quires that the death ce | in signed by the attentification of Health and Mental F | |
| AL RECORDS, P.O. | The law requires that the death ce | e has been signed by the attent te Dept. of Health and Mental H | |
| - VITAL RECORDS, P.O. | SICIAN: The law requires that the death ce | certificate has been signed by the attent the State Dept, of Health and Mental F. | |
| N OF VITAL RECORDS, P.O. | NG PHYSICIAN; The law requires that the death ce | fler this certificate has been signed by the attent eath with the State Dept, of Health and Mental F | |
| VISION OF VITAL RECORDS, P.O. | ATTENDING PHYSICIAN; The law requires that the death ce | ECTOR; After this certificate has been signed by the attents after death with the State Dept, of Health and Mental F | |
| DIVISION OF VITAL RECORDS, P.O. | THE DRATTENDING PHYSICIAN; The law requires that the death ce | RAL DIRECTOR: After this certificate has been signed by the attent 72 hours after death with the State Dept, of Health and Mental F | |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | HE HOSE TAL OR ATTENDING PHYSICIAN; The law requires that the death ce | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fube fried within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |

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| 1. OECEOENT'S NAME (F | | yette | | | Cray, | | | 2. DATE OF DEAMONTH | . NO. | YE | AD | TIME OF DEATH |
|---|--|--|---|--|--|--|------------------------|--|--|--|--|---|
| 4. SOCIAL SECURITY NU | | I s. sex | 6. AGE (In yrs. les | | IF UNDER 1 YEAR | IF UNDER | 04.000 | 7. DATE OF BIRT | | 100 | | CE (State or Foreign |
| 577-70-076 | | 1 ,M 2 F | | YRS. | MONTHS DAYS | HOURS | MIN. | (Month, Day, Ye | er) | 0 | Country) | |
| 9a. FACILITY NAME (# no | | X | l. 18 | | 9b. CITY, TOWN | OR LOCATIO | ON OF DE | 4-17-7 | | | OF DEATH | ngton, D. |
| Prince Ge | orges C | | eneral Ho | ospit | | everl | | | | | | rges Co. |
| 10e. STATE | 10b. COUNT | Υ | | 10c. CIT | Y, TOWN OR LOCA | TION | | | | | 100 | . INSIDE CITY |
| Maryland | Prin | nce Georg | jes | La | rgo | | | | | | 1 (| MES 2 □ NO |
| 10e. STREET AND NUMB | ER | | | | 10 | . ZIP CODE | | | 10g. | CITIZEN | OF WHAT | COUNTRY? |
| 544 Harry | S. Trum | nan Dr | | | | 207 | 72. | | | USA | | |
| 11. MARITAL STATUS 1 Dever Married 2 3 Widowed 4 0 | | FORCES? | NT EVER IN U.S. AR 1 YES 2 X WAR OR DATES | | If yes, sp | | n, Mexica: | IIC ORIGIN? (Spec n, Puarlo Rican, at | | | Specific | |
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| (Specify Elamentary/Secondar | _ | CATION completed) College (1-4 or 5 | (G | ilve kind of a Do NOT us | USUAL OCCUPATI work done during ma se retired.) | ON OST of working | g | 16b. KIND C | F BUSINES: | s/INDUST | HΥ | |
| 12th gra | | | | stud | ent | 40 41 | | ME (Fig. 1 AF) | e-tota - A | > | | |
| Lafayette | | Cro | | | | | | ME (First, Middle, N | | ., | | |
| LALAYELLE 9a. INFORMANT'S NAM | | Sr. | 10 | h. MAII ING | AOORESS (Street | | | averne | | | (a) | |
| Gail Lync | | | | | Harry S | | | | | | 0772 | |
| 20a. METHOD OF OISPO | SITION | - | | OF DISPO | SITION (Name of ca | | | | C. LOCATIO | | 0 / / | |
| Buriel 2 Crem | ation 3 Rem | loval from State | Harn | | Memoria | l Par | k | | Land | over | ME |) |
| 21. SIGNATURE OF FUNE | | | | CILY | 22, NAME A | NO ADDRES | S OF FA | CILITY J. B. | Tenki | ns F | iner | al Home |
| Jum | ry (| ' ne | es of | 2. | | | | Rd. La | | | | |
| 23. PART I. Enter the | | complications th | | | not enter the m | oda of dyl | ng, suc | h ee cardlec or | respirator | y erreat, | | Approximete |
| IMMEDIATE CAUSE | (Final | 1000 | | | | | | | | | | |
| disease or condition resulting in death) | \rightarrow | Cuncho | | | 7 | | | | | | | Onset and Deatl |
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| Sequentielly list con | ditione, | OUE TO | O (OR AS A CONSE | OUENCE O | F): | | | | · | | | Onset and Deat |
| f eny, leading to im | mediate | OUE TO | | OUENCE O | F): | | | | | | | Onset and Death |
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| if eny, leading to im cause. Enter Unicause. Enter Unicause. Enter Unicause or ithat initiated events resulting in death) L PART II. Other eignli 25. WAS CASE REFERRE EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 Whomicide 29a. CERTIFIER (Check only) | D TO MEDICAL Pending investigation Could not be determined | DUE TO C. DUE TO d | O (OR AS A CONSE | OUENCE O OUENCE O OUENCE O Tesulting 28b. Tih 1:30 Onne, farm, | F): F): 26. F OTHER: 4 Nursing Hotel E OF 28c. IN W I Street, factory, offi | LACE OF DI me 5 Pe JURY AT ORK? YES a and place | EATH (Ch | eck only one) 6 Other (Special Subjection of the Country of the C | (ES 2 N N N N N N N N N N N N N N N N N N | y occurrence or frumary, in stated. | ED Rural Route | RE AUTOPSY FINDINGS MLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 \(\text{NO}\) Number, Prince |
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| if eny, leading to im cause. Enter Unicause. Enter Unicause. Enter Unicause or ithat initiated events resulting in death) L PART II. Other eignli 25. WAS CASE REFERRE EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 WHomicide 29a. CERTIFIER (Check only) | D TO MEDICAL Pending Investigation Could not be determined ERTIFYING PHYS MEDICAL EXAMINITY | DUE TO | O (OR AS A CONSE | OUENCE O OUENCE O OUENCE O Tesulting 28b. Tih 1:30 Onne, farm, | F): F): 26. F OTHER: 4 Nursing Hotel E OF 28c. IN W I Street, factory, offi | PLACE OF DI | EATH (Christelland) NO | eck only one) 8 Other (specification) 28d. DESCRIBE SUDJEC 281. LOCATION (5447 Har 300 Ges to the cause(s) a time, data and planets | y) HOW INJURY TY TY Treet and N.N. Street and N.N. TY Treet and manner a | o occurrent or frumary Pumary or the cate of the cate | ED Bural Route Dr Mary Busse(a) ar | RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number, Prince laid and manner as stated. |
| if eny, leading to im cause. Enter UNDER CAUSE (Disease or I that initiated events resulting in death) L PART II. Other eignif 25. WAS CASE REFERRE EXAMINER? YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29e. CERTIFIER 1 Check only one) | D TO MEDICAL Pending investigation Could not be determined ERTIFYING PHYS AEDICAL EXAMINITIES OF THE PERSON OF THE PHYS AEDICAL EXAMINITIES OF THE PHYS AEDICAL | b. DUE TO c. DUE TO d | O (OR AS A CONSE | OUENCE O OUENCE O OUENCE O Tesulting 20b. Tin 1:30 Dome, ferm, | F): F): 26. F OTHER: 4 Nursing Hotel E OF 28c. IN W I Street, factory, offi | PLACE OF DI THE S RESULT REPOR | EATH (Chiefdence | eck only one) 8 Other (specification) 28d. DESCRIBE SUDJEC 281. LOCATION (5447 Har 300 Ges to the cause(s) a time, data and planets | y) HOW INJURY TY TY Treet and N.N. Street and N.N. TY Treet and manner a | o occurrent or frumary Pumary or the cate of the cate | ED Rural Route Dr Mary Buso(a) ar | RE AUTOPSY FINDINGS ILLABLE PRIOR TO MPLETION OF CAUSE DEATH? YES 2 NO Number; Prince latid and manner as stated. |

| 24a. WAS AN AUTOPSY PERFORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE |
|--------------------------------|---|
| XX 120 7 1 10 | OF DEATH? |

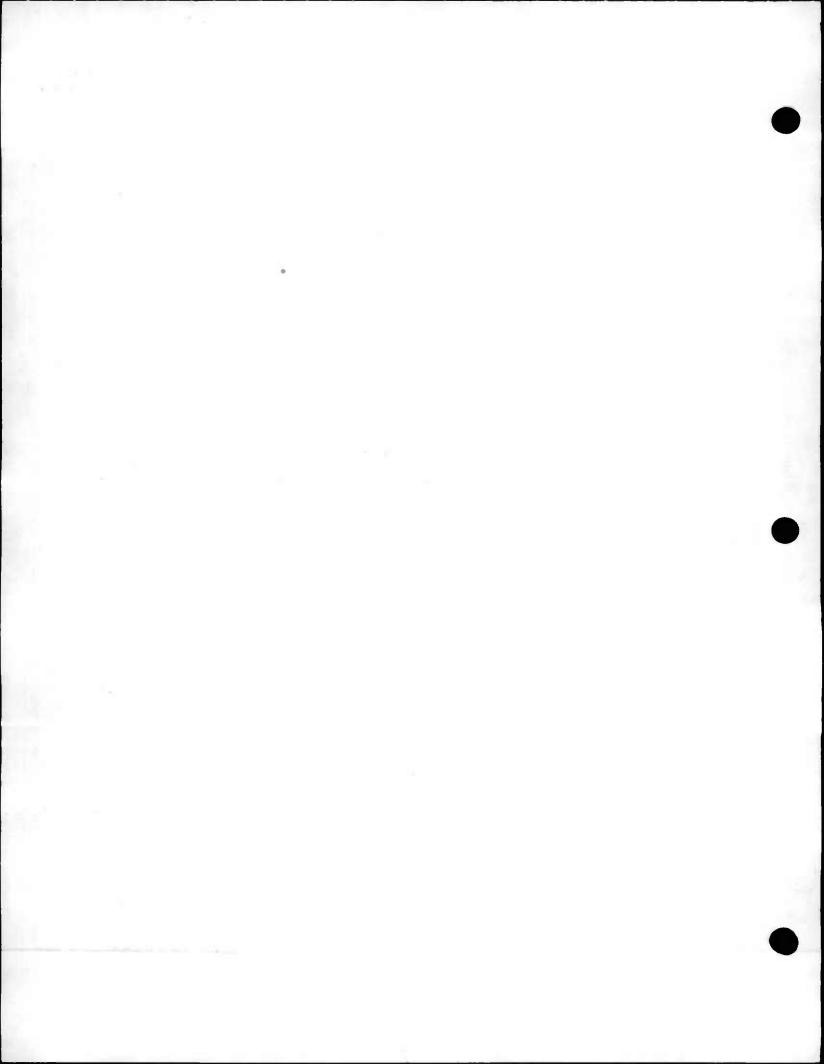
| | | | YES 2 □ NO |
|---|--|---------------------------------------|---|
| 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATH (C | heck only one) |
| EXAMINER? YES 2 □ NO | HOSPITAL: 1 ☐ Inpatient 25 ER/Outpatient 3 ☐ DOA | OTHER: 4 Nursing Home 5 Residence | 6 ☐ Other (Specify) |
| 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 11-24-90 1:3 | ME OF LOURY AT WORK? 1 VES X NO | 28d. DESCRIBE HOW INJURY OCCURED Subject shot |
| 3 Suicide 6 Could not be determined | | , street, factory, office Home | 281. LOCATION (Street and Number or Rural Route Number, 544) Alford, State Truman Dr., Prince |

| 9a. CERTIFIER (Check only | 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place | e, and due to the cause(s) and manner as atsted. |
|------------------------------|--|--|
| one) | XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occur | ured at the time, data and place, and due to the cause(a) and manner as at |

MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore, MD 21201 31. DATE FILED (Month, Day, Year) 32, REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

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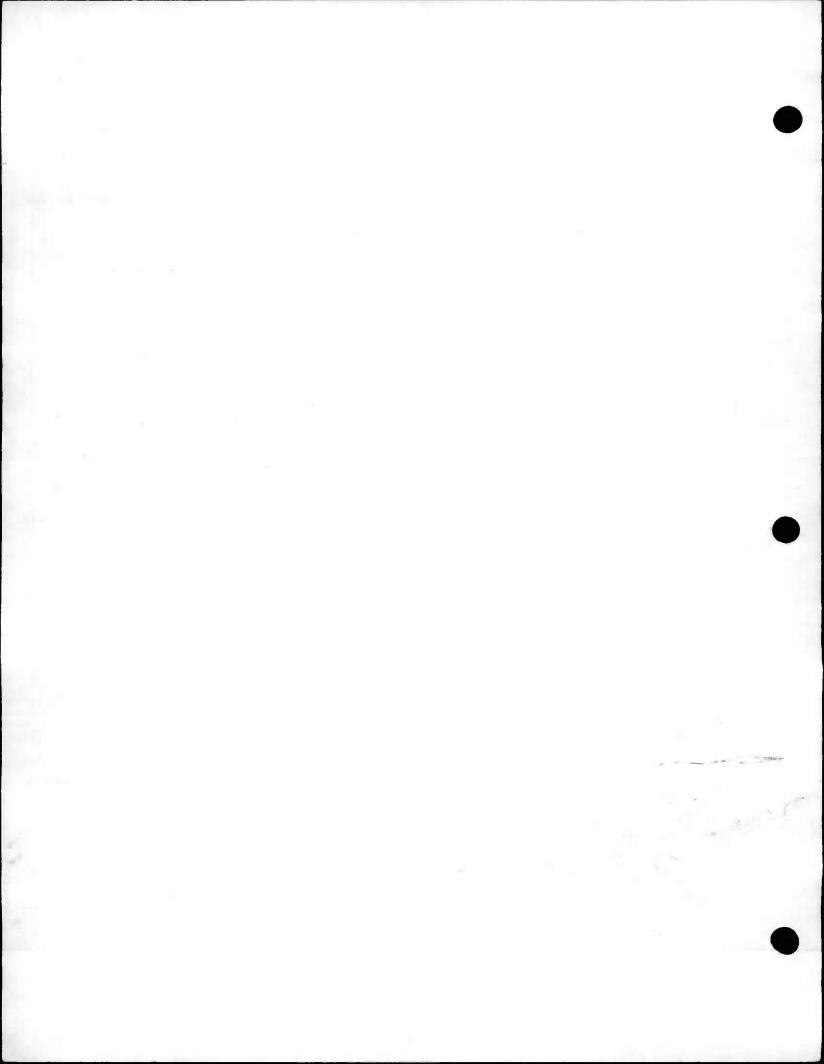
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| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 nours after death. Page 6 may be retained by the hos | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
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32. REGISTRAR'S SIGNATURE

| 1 - FOR STATE REGISTRAR | STATE OF I | CE | ERTIF | ICATE O | DEA | IH | | REG. NO | | | | |
|--|--|--|--|--|---|--------------------------------|---|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | isa | | | Mille | er | | 2. DATE (| 20 – 90 | AY | YEAR | | OF DEATH |
| 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. las | t birthday) | IF UNDER I YEAR | IF UNDE | R 24 HRS. | 7 OATE | OF BIRTH | | | HPLACE (S | State or Foreign |
| 094-54-6905 | 1 🗆 M 2 💢 🗜 | 26 | YRS. | MONTHS DAYS | HOURS | MIN. | Aus | Day, Year) | 196 | 4 Coun | | York |
| 9e. FACILITY NAME (If not institution, give | | | | 9b. CITY, TOWN | OR LOCAT | ION OF DI | | , ,, | 9c. COU | NTY OF | | |
| 5713 Jamestown I | Road | | | H | yatts | svill | .e | | Prin | ice (| Georg | ges Co. |
| RESIDENCE OF DECEDENT 100. STATE 10b. COUNT | Υ | | 10c. CIT | Y. TOWN OR LOC | ATION | | | | | | I tod INS | SIDE CITY |
| | ce Geor | | | ttsvil | | | | | | | LIN | AITS? ES 2 NO |
| 10e. STREET AND NUMBER | ce Geor | ges | lliye | | of. ZIP COD | E | | | 10g. CIT | IZEN OF | WHAT COL | |
| 5713 Jamestown | Road # | 4 | | 2 | 0782 |) | | | U. | S. | Α. | |
| 11. MARITAL STATUS | 12. WAS DECEDE | NT EVER IN U.S. AR | | 13. WAS D | CENDENT | OF HISPAI | | 1? (Specify Ye | | 14. RAC | | ricen Indian, |
| 1 Never Merried 2 Merried 3 Widowed 4 Divorced | | I ☐ YES 2 🕅 WAR OR DATES | NO | 1 🗆 Y | S 2 X | Specifi | | tican, etc.) | | - | ack | arc. |
| 15. DECEDENT'S EO | | | | USUAL OCCUPA | | | 16b. | . KIND OF BU | SINESS/INI | DUSTRY | | |
| (Specify only highest grad Elementary/Secondary (0-12) | College (1-4 or 5 | Ho | ilve kind at . Do NOT u | work done during i se retired.) | nost of work | ing | | | | | | |
| F | our vea | rs S | ales | Assoc | ciate | 9 | I | riva | te I | ndu | ıstr | У |
| 17. FATHER'S NAME (First, Middle, Last) Wyatt Miller | | | | | | HER'S NA | | Middle, Meider | Surname) | | | |
| 19e. INFORMANT'S NAME (Type/Print) | | 191 | b. MAILING | ADDRESS (Stree | and Numbe | or or Rural | Floute Numb | ber City or Tox | vn. State. Zi | o Code) | | |
| Wyatt Miller | | | | reenwo | | | | | | N | Т | 08609 |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Commation 3 Ran | | | OF DISPO | SITION (Name of | | | UE | | CATION - | - | | |
| 1 Burial 2 K3-Oremation 3 Ban 4 Donation Diher (Specify) | noval from State | | MICE) | | | | | | | - 1 | D | 0 0- 1 |
| | | - L Ced | ar I | H111 C1 | remat | orv | • | Su | 1112 | ma. | Ρ. | U. LO.P |
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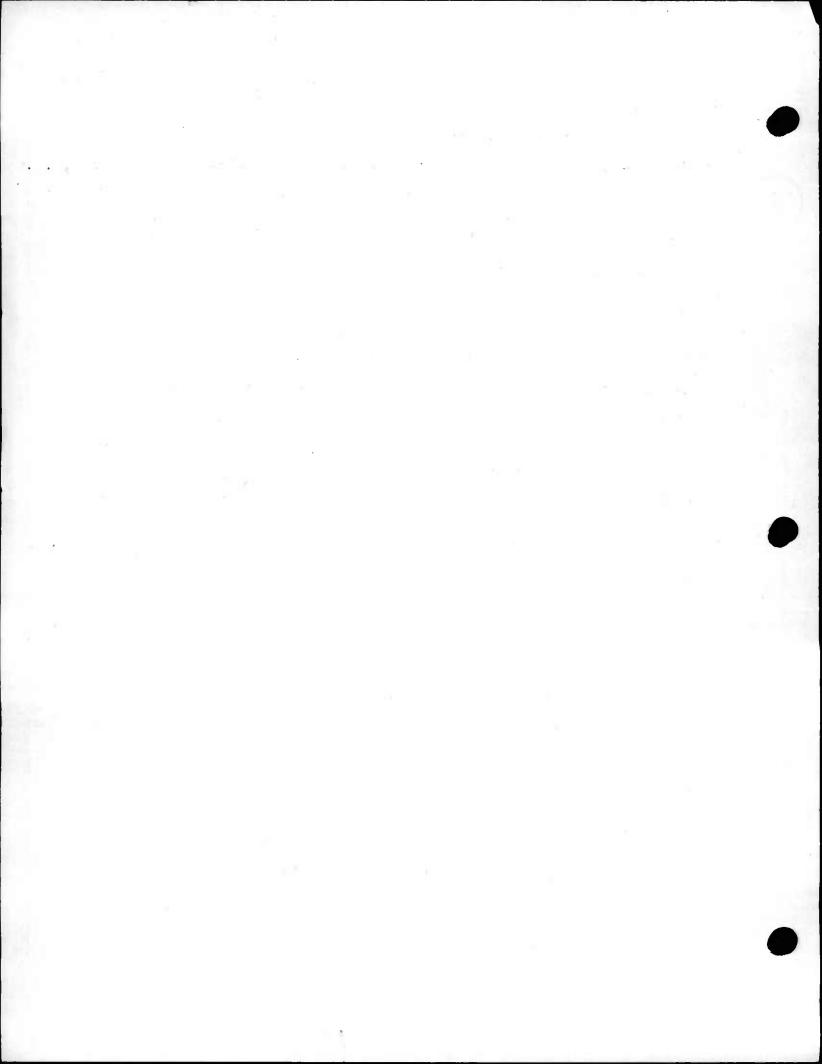
| examiner must be notified at once. | IMPORTANT: if Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | IMPO |
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| | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | be file |
| e funeral director, page 5 should be detache | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached | TO TH |
| death. Page 6 may be retained by the hosp | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25 mous after death. Page 6 may be retained by the hosp | TO TH |
| BALTIMORE, MARYLAND | DIVISION OF VITAL RECORDS, P.O. BOX 13146, | |

| TOTE Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington State Washington Rehabilitation Center Fort Washington State Washington Center Fort Washington State Washington Center Fort Washington State Washington Center Fort Washington State Washington Center Fort | Ashington Prince George's 10d. INSIDE CITY LIMITS? |
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| 4. SOCIAL SECURITY NUMBER 135-30-4959 90. FACILITY NAME (if not institution, give street end number) Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Road 100. STREET AND NUMBER 12021 Livingston Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES ZONO 15. WAS DECENDENT IN YES ZONO 16. CITY, TOWN OR LOCATION DECEDENT STATES TO STATES TO STATE STATES TO STATE STATES TO STATES TO STATE STATES TO STATE STATES TO STATES | # UNDER 24 HRS. 7. DATE OF BIRTH (Month, Dey, Year) — — — 09—18—10 Paterson, N.J. LOCATION OF DEATH Prince George's N 104. INSIDE CITY LIMITS? I N YES 2 □ NO IOG. CITIZEN OF WHAT COUNTRY? |
| 135-30-4959 9a. FACILITY NAME (if not institution, give street end number) Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Residence of Decedent 10a. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION MD Prince George's Fort Washington Road 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED II. WAS DECEDENT EVER IN U.S. ARMED II. WAS DECEDENT EVER IN U.S. ARMED II. WAS DECEDENT II. WAS DECEDE | Min. Og. 18-10 Paterson, N.J. |
| Fort Washington Rehabilitation Center Fort Washington Rehabilitation Center Fort Washington Residence of decedent 10e. STATE 10e. STATE 10e. STATE 10e. CITY, TOWN OR LOCATION MD Prince George's Fort Washington Road 10f. ZIP 12 021 Livingston Road 11. MARITAL STATUS 11 Never Married 12. WAS DECEDENT EVER IN U.S. ARMED II yes, apecify II yes, apecify II YES ZIP NO 15. WAS DECENDENT II YES ZIP NO 16. CITY, TOWN OR LOCATION 17. WAS DECEDENT II YES ZIP NO 18. WAS DECENDENT II YES ZIP NO 19. WAS DECENDENT II YES ZIP NO 10. CITY, TOWN OR LOCATION | Prince George's 10d, INSIDE CITY |
| 100. STREET AND NUMBER 12021 Livingston Road 11. MARITAL STATUS 1 Never Merried 2 Married 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES ZYNO If yes, specify IF YES, GIVE WAR OR DATES 13. Wildowed 4 Divorced 101. ZIP 12. WAS DECEDENT EVER IN U.S. ARMED IS WAS DECEDED IN U.S. ARMED IS WAS DECEDED IN U.S. AR | ngton Limits? 1 X ves 2 □ NO 10g. CITIZEN OF WHAT COUNTRY? |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES* | |
| 3 Widowed 4 Divorced IF YES, GIVE WAR OR DATES* | 20144 Office Beaces |
| | IDENT OF HISPANIC ORIGIN? (Specify Yee or No— Ify Cuben, Mexican, Puerto Rican, etc.) XNO Specify: White |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of | 16b. KINO OF BUSINESS/INDUSTRY |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Masters MA 16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of life. Do NOT use retired.) Masters MA School Teach 17. FATHER'S NAME (First, Middle, Last) | |
| 17. FATHER'S NAME (First, Middle, Last) 18. | 18. MOTHER'S NAME (First, Middle, Melden Sumeme) |
| Samuel James Dougherty | Margaret Hayden |
| 19a, INFORMANT'S NAME (Type/Print) 19b, MAILING ADDRESS (Street and N | Number or Rural Route Number, City or Town, State, Zip Code) |
| P Richard H. Meade 706 Loch Ness Greet and N | Circle, Ft. Washington, Md. 20744 |
| 20s. METHOD OF DISPOSITION 1 | tery, cremetory or Alexandria, Virginia |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND AI George | ADDRESS OF FACILITY e P. Kalas Funeral Home Oxon Hill Rd. Oxon Hill, Md. 20745 |
| 23. PART i. Enter the discusses, or complications that caused the death. Do not enter the mode of shock, or beent fellure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR #S A CONSEQUENCE OF): | |
| Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | non |
| PART ii. Other significant conditions contributing to desth but not resulting in the underlying cs | PERFORMED? AVAILABLE PRIOR TO |
| DRKINSON 5 Docase, Mustiples | DIPLYSIAN 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL 26. PLACE | CE OF DEATH (Check only one) |
| EXAMINER? 1 YES 2 NO HOSPITAL: 1 Inpetient 2 ER/Outpetient 3 DOA 4 Unursing Home 5 | 5 Residence 6 Other (Specify) |
| EXAMINER? 1 YES 2 NO 1 Inpetient 2 ER/Outpetient 3 DOA 4 Tourning Home 5 27. MANNER OF DEATH 1 Netural 5 Pending 1 Notice 1 Section 1 DOA 4 Tourning Home 5 Notice 1 DOA 1 DOA 4 Tourning Home 5 Notice 1 DOA | AY AT 28d. DEŞCRIBE HOW INJURY OCCURED KY |
| 2 Accident Investigation | AY AT 28d. DEŞCRIBE HOW INJURY OCCURED KY |
| 2 Accident Investigation 3 Suicide 6 Could not be building, etd. (Specify) | 28d. DESCRIBE HOW INJURY OCCURED 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) and place, and due to the cause(s) and menner as stated. |

rem 27 (Type, Print)
1328 Southern Ave. S.E. #3C1 Wash., D.C. 20032

Michael D. Levine M.D. 13
31. DATE FILED (Month, Day, Volar)
NOV 2 9 90

Julia Davidson-Randale



| BALT | r death. | ne funera | ехаш |
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| | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-shours after death. | TO THE FUNEPAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funers be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | MPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical exami |
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| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | e death | Mental Mental | lury, o |
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

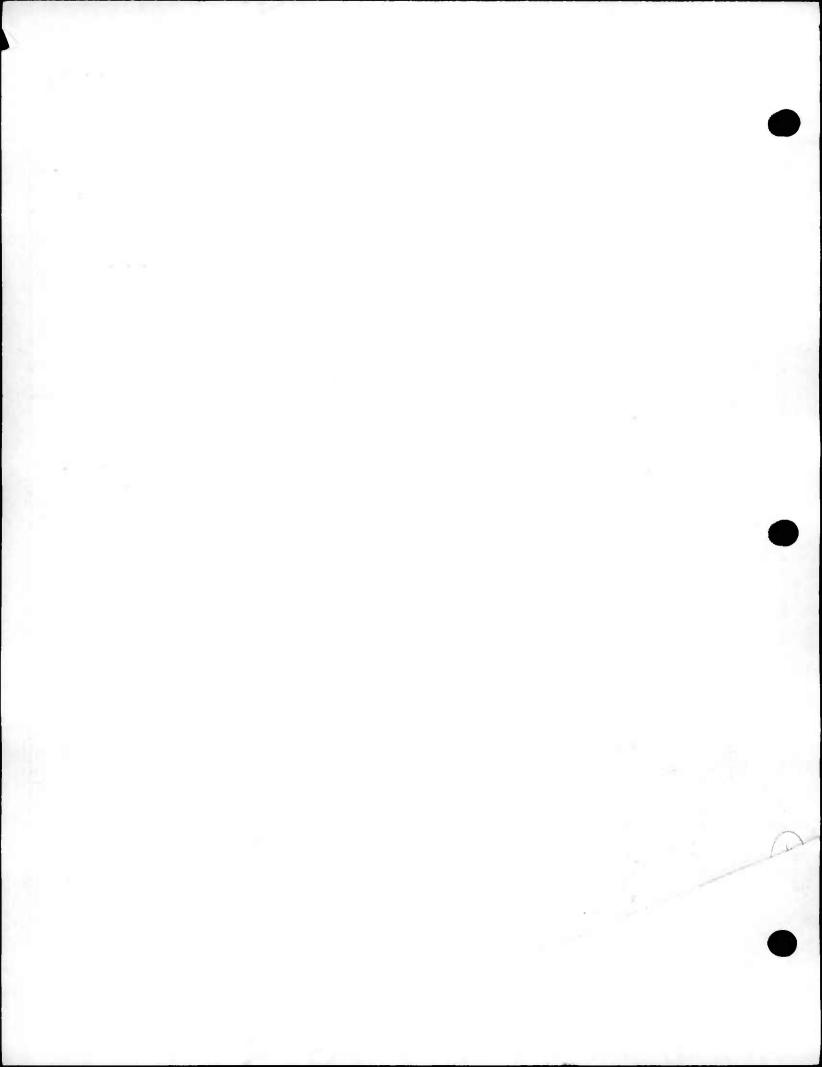
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| BALTIMORE, MARYLAND 21203-3146 | GIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Entire thas been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| 13146, | recuted with and comple burial, cre- | atic even |
| VITAL RECORDS, P.O. BOX 13146, | CIAN: The law requires that the death certificate be ex- entificate has been signed by the attending physician a the State Dept. of Health and Mental Hygiene prior to | or item 23 shows any injury, or other traum |

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR

90 34450 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| 1, DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH | | | | | | | | | | | | |
|---|---|---------------------------|------------------------|--------------------------------|--------------|----------|--------------|---------------|--|-------------|----------------------|--|
| | | | | | | | | | 2:30 AM M | | | |
| 4. SOCIAL SECURITY NUMBI | | | | | IF UNDER | 1 YEAR | IF UNDER | 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTI | HPLACE (State or Foreign |
| 193-01-6583 1 1 M 2 X F 74 YRS. | | | | | | | The second | | 5 15 1 | 6 | | vell Penn. |
| 9a. FACILITY NAME (If not ins | | | | | 9b. CITY | TOWN | OR LOCATI | ON OF DE | EATH | 9c. CO | UNTY OF E | DEATH |
| 6612 Wilbur | n Dri | ve | | | C | api | tol F | leigh | nts | Pri | nce (| George's |
| 10a. STATE | 10b. COUNTY | 1 | | 10c. CITY | Y, TOWN C | R LOCA | TION | | | | | 10d. INSIDE CITY |
| Maryland | Prin | ce Georg | je ts | C | apit | ol 1 | Heigh | nts | | | | LIMITS? |
| 106. STREET AND NUMBER 106. ZIP CODE 109. CITIZEN OF WHAT C | | | | | | | | WHAT COUNTRY? | | | | |
| 11. MARITAL STATUS | 20/45 | | | | | | | | | | | |
| 1 Never Married 2 🔯 | Married | FORCES? 1 | XXYES 2 MAR OR DATES | NO | | f yes, s | pecify Cubi | ın, Mexice | in, Puerto Ricen, etc.) | es or No- | Blec | E — Americen Indian, ik, White, etc. |
| 3 Widowed 4 Divor | ced | IF TES, GIVE T | MAN ON DATES | | , | I ∐ YE | S 2 📉 NO | Specify | y: | | Callo | asian |
| | DENT'S EDU | | 16a, D | ECEDENT'S | USUAL O | CCUPAT | ION | | 16b. KIND OF B | USINESS/II | | astan |
| Elementary/Secondary (0- | - | College (1-4 or 5 | +) | Sive kind of v a. Do NOT us | se retired.) | uuring m | IOSL OF WORK | ny | . 17-63-5 | | | |
| 21/2 Years | | NO | C | ashie | r | | | | Safe | way 1 | Foods | 5 |
| 17. FATHER'S NAME (First, Mic | | 1- | | | | | 18. MOT | | ME (First, Middle, Mald | | | |
| Stephen | | OCK | | | | | | | nes Hunyac | | | |
| | 19a. INFORMANT'S NAME (TyperPrint) John H. Meyers 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 A-F | | | | | | | | | | | |
| 29a METHOD OF DISPOSITION 1 Description 6 Other (| 3 🗆 Rem | oval from State | 20b. PLACE | of piseos | State | me at ce | etera | metory or | Cemetery C | helte | - city or T enhan | own, State n, Maryland |
| 21. SIGNATURE OF FUNERAL | SERVICE LIC | ENSEE | 9 | | 22. | NAME A | AND ADDRE | SS OF FA | CILITY Lee F | unera | al Ho | me, Inc. |
| Jeuann | e (| 2 | A T | | 6 | 633 | Old | Alex | ander Fer | - | d Cli | nton, Md |
| 23 PART I. Enter the dis | seases, or o | complications the | at caused the d | eath. Do n | not enter | the m | ode of dy | ing, auc | h ae cardiec or rec | piratory a | rreat, | Approximate Interval Between |
| IMMEDIATE CAUSE (Fin | | ΔA | uso on ouch in | 0. | | | | 0 | . 1 | | | Onset and Death |
| disease or condition resulting in death) | + | · Misto | MADE | el A | 4 | J | IN | TA | RITION | 1. | | |
| | | DUE TO | OR AS A CONSI | EQUENCE OF | F): | ^ | 1 | | 1.0 | - 0 | | |
| Sequentially list condition | ons. | a(| Shon | A15 | 1 | 4 | 2/7 | 4 | 0) 171 | SHE | 73 | |
| If any, leading to immed cause. Enter UNDERLYII | liate | OUE TO | OR AS A CONS | QUENCE OF | F):¹ | - | . ~0 | · - ! | C | | | |
| CAUSE (Disease or Injui | | c. DUE TO | O (OR AS A CONSI | OLIENCE OF | 70 | 1 | 71 | 191 | (7 | | | + |
| that initiated events resulting in death) LAS1 | | 502 10 | (OII AS A CONSI | COLINCE OF | ·). | | | | | | | |
| | | d | | | | | | | | | | |
| PART II. Other significan | t condition | e contributing to | death but not | resulting | in the ur | derlyi | ng cause | given in | Part I. 24a. WAS | AN AUTOPS | Y 24 | b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| l | | CHIE | 2414 | T | 1741 | 7 | hn | 119 | 0 | 2 NO | | COMPLETION DF CAUSE OF DEATH? |
| | | | | | | | | • | ` | | | 1 YES 2 NO |
| | | | | | | | | | | | | |
| 25. WAS CASE REFERRED TO EXAMINER? | MEDICAL | HOSPITAL: | | | | | PLACE OF E | DEATH (Ch | neck only one) | | | |
| 1 TES 2 THO | | 1 Inpatient 2 | ☐ ER/Outpatient | 3 DOA | 4 Nur | | me 5 R | eldence | 6 Other (Specify) | | | |
| 27. MANNER OF DEATH | | 28a. DATE Of (Month, I | F INJURY Day, Year) | 26b. TIM | IE OF | | JURY AT | | 28d, DESCRIBE HOV | V INJURY O | CCURED | |
| | Pending nvestigation | | | | М | | YES 2 | NO | | | | |
| 3 Suicide 6 Could not be 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | | | | | | | | | | | | |
| 4 Homicide | letermined | | | | | | | | | | | |
| | FYING PHYS | ICIAN: To the best o | of my knowledge, o | leath occurr | ed at the t | ime, dat | te and place | , and due | to the cause(e) end r | nanner as s | tated. | |
| one) 2 MEDI | | | | | | | | | (e) end manner ee stated. | | | |
| 29b, SIGNATURE AND TITLE | 296. SIGNATURE AND TITLE OF CERTIFIER 29d. DATE SIGNED (Month (Day, Year) | | | | | | | | D (Month / Dept., Year) | | | |
| Jesen a W / Me 1 1 199/2 1 1/123/90 | | | | | | | | | | | | |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | | | | | | | | |
| Terrance | Terrance A. McGuire MD 311 Addison Road Capitol Heights Md | | | | | | | | | | | |
| 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | | | | | | | | | | |
| NUV 2 9 '9U | NOV 2 9 '90 July Savidson-Kandell | | | | | | | | | | | |



| e hos | THE FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached any antimity of the funeral directors. | IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hosp | ld be | d at o |
| retaine | 5 shou | notifie |
| ay be | page | pe 1 |
| ы 9 ы | rector, | mus |
| th. Pag | ieral di | miner |
| er dea | the fur | exa i |
| urs aft | in by 1 | edica |
| 24 M | filled ion or | the m |
| within | pletely | rent, |
| cuted | nd com | tic en |
| be exe | clan ar | auma |
| ificate | physical price price | her tr |
| th cert | ending Hvoir | or of |
| he dea | the att | njury, |
| that t | ed by | any i |
| aduires | an sign | hows |
| aw re | las bee | 23 sl |
| N: The | State 1 | item |
| SICIA | certif | d, or |
| IG PHY | ter this | narke |
| ENDIN | DR: Af | 1 si co |
| TIA AC | INECTION OF THE CT | em 2 |
| YTAL (| RAL | E 11 11 |
| HOSE | FUNE | TAN |
| THE | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the first winting 20 hours after death with the State Dent of Health and Mental Horiene infort to burkal cremation or removal. | MPOF |
| - | T. A | - |

| | | | | | | | | | | 20 | J | 1045 |
|------------------|--|---------------------------|-------------------------------------|-------------------|---------------------------------|--------------------------|------------------------|-------------------|------------------|-------------------|-------------|------------------------------|
| | FOR STATE REGISTRAR | STATE OF M | ARYLAND / [CE | | MENT OF H | | | | YGIEN EG. NO. | E | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | EN | MA | TA | Lik | | | DATE OF | DEATH DA | 5- 9 | | TIME OF DEATH 4.40 M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. last I | _ | IF UNDER 1 YEAR | IF UNDER 2 | 4 HRS. 7. | DATE OF I | BIRTH | 8.1 | BIRTHPLA | CE (State or Foreign |
| | 193-16-5603 | 1 🙀 M 2 🗌 F | 65 | - " | MONTHS DAYS | HOURS | MIN. | (Month, Da Jan | ly, Year) | 1.00 | Country) | ylvania |
| | 9e. FACILITY NAME (If not institution, give st | 1 . | | | 9b. CITY, TOWN | | | Н | | 9c. COUNTY | OF DEATH | |
| TOT. | RESIDENCE OF DECEDENT | D # | DSPITAL | | C | LIN. | ION | | | | P. G | -County |
| Ĕ, | 10a. STATE 10b. COUNTY | , | | 10c. CITY | TOWN OR LOCA | TION | | | | | 10d | I. INSIDE CITY |
| D | Maryland Prince | Georges | | Sui | tland | . ZIP CODE | | | | 10g. CITIZEN | | YES 2 NO |
| FUNERAL DIRECTOR | 3533 Terrace Dr. | Apt. C | | | 10 | 207 | | | | | S.A. | COUNTRY? |
| 5 | 11. MARITAL STATUS | | EVER IN U.S. ARM | | | ENDENT OF | | | | | | American Indien, |
| BY F | 1 Never Merried 2 X Merried 3 Wildowed 4 Olvorced | IF YES, GIVE W | | | | ecify Cuben, 2 RNO | | ruerio Hica | n, etc.) | | Specify: | |
| ED | 15. DECEDENT'S EDU (Specify only highest grade | CATION | 16a, DEC | EDENT'S U | USUAL OCCUPATION done during me | ON ost of working | , | 16b. KII | OF BUS | SINESS/INDUST | | nite |
| COMPLET | Elementary/Secondary (0-12) | College (1-4 or 5+ | His f | Oo NOT use | retired.) | • | | _ | | | | - 1 |
| ₽ | 17. FATHER'S NAME (First, Middle, Last) | | <u> </u> | ager | | | ER'S NAME | | | ant Cha | ain | |
| | Joseph Matalik | | | | | | | | ie, Maloen | Surname) | | |
| BE | 19e. INFORMANT'S NAME (Type/Print) | | 19b. | MAILING | ADDRESS (Street | | y Bed or Rural Rout | | City or Tow | n, State, Zip Coo | de) | |
| 5 | Juanita Matalik | | 500 | 3533 | Terrac | a Dr | Ant | c Si | uit1a | and, Ml |). 20 |)746 |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 □ Cremation 3 □ Rem | and from State | | F DISPOS | ITION (Name of ce | | | | 7 | CATION — City | | |
| | 4 Donation S Other (Specify) | A State | | | Veteran: | s Ceme | eterv | | Che | eltenha | am. N | 1D |
| V | 21, SIGNATURE OF FUNERAL SERVICE | ENSEE | | | 22. NAME A | ND ADDRESS | S OF FACILI | ITY | | 4308 9 | Suit1 | land Rd. |
| | Dryn A | / fere | au. | | Rober | t E. V | Wilhe | 1m, | Inc. | Suit1a | and, | MD. 20746 |
| | 23 PART I Enter the diseases, or on the shock for heart failure. | complications that | caused tha dee | th. Do n | ot anter the mo | ode of dyln | ng, auch a | a cardiac | or reap | ratory arrest | , | Approximete interval Between |
| (3) | iMMEDIATE CAUSE (Final disease or condition | CD. | . 101: | + | - 1 | | 1. | COT 12 | | | | Onaet and Death |
| | resulting in deeth) | DOE TO | OR AS A CONSEQU | JENGE OF | wixe | ing | Hes | arch | 2 | | | |
| NO | Sequentially list conditions, | b | OR AS A CONSECU | IENCE OF | . | ~ | | | | | | |
| CERTIFICATION | If any, leeding to immediate cause. Enter UNDERLYING | 502.10 | ON AS A CONSECU | JENCE OF | ,. | | | | | | | |
| IFIC | CAUSE (Diseeea or Injury that Initiated events | DUE TO | OR AS A CONSECU | JENCE OF |): | | | | | | | |
| ERT | resulting in death) LAST | d | | | | | | | | | | |
| LC | PART II. Other significant condition | e contributing to | death but not ra | auiting i | n the underlyin | g cause gl | Iven in Pa | rt I. 24 | a. WAS AN | AUTOPSY | 24b. WE | RE AUTOPSY FINDINGS |
| EDICA | | | 100 | | | | | 1 | PERFOR | 4 4 | CO | MPLETION OF CAUSE OEATH? |
| MED | | | | | | | | | | 74 | 1 1 | YES 2 NO |
| ä | | | | | | | | | | | | |
| CIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 26. P | LACE OF OE | ATH (Check | only one) | | | | |
| ြတ | 1 U YES 2 NO | 1 Unpatient 2 | ER/Outpatient 3 | | 4 - Nursing Hor | | | | | | | |
| PHY | 27. MANNER OF DEATH 1 Natural S Pending | 28e. DATE OF (Month, D | | 26b. TIMI INJI | URY W | JURY AT ORK? YES 2 | | ad. DEŞCR | IBE HOW I | NJURY OCCUR | EO | |
| ED BY | 2 Accident Investigation 3 Suicide a Could not be | 26e. PLACE O building, | F INJURY — At hon atc. (Specify) | ne, farm, s | treet, fectory, offi | 00 | 20 | | ON (Street | and Number or | Rural Route | Number, |
| Ш | 4 Homicide determined | | | . : - | | | | | | | | |
| 1 4 | one) | CIAN: To the best of | | | | | | | | | line. | generanismi |
| COM | 2 MEDICAL EXAMINE | R: On the beele of e | ramination end/or in | rvestigatio | n, in my opinion, | | | | a piece, er | | | |
| BE | 29b. SIGNATURE AND TITLE OF CERTIFIE | | | | | 29c. LICE | NSE NUMBE | ER / | | 29d, DATE S | GNED (Mo | onth, Day, Year) |
| 2 | 30. NAME AND ADDRESS OF PERSON WE | O COMPLETEO CAUS | SE OF DEATH (ITEM | 27) (Type. | Print) | 177 | 0470 | 06 | | 1// | 4 | 140 |

N. 8926 WOOD YARD

32 AEGISTAR'S SIGNATURENDAD

JUNE DAVIDSON

10 COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)

1 UA

21. DATE FILED (MONTH, Day, Year)
NOV 2 7 '90

DHMH-16 Rev 1/89

| BALTIMORE, MARYLAND 21203-3146 | 24 hours after death. Page 6 may be retained by the hospital or attending physician. | L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | |
|--|---|---|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | L OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. | L DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the bours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | |

TO BE COMPLETED BY FUNERAL DIRECTOR

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the thosp of THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1. DECEDENT'S NAME (First | Middle, Last) | | · | | 1 | AA | 201 | 10 | | 2. DATE OF DEATH | 7 | YEAR | 3. TIME OF DEATH |
|--|---------------------------------|--------------------|---------------|-----------|------------|----------------|-------------|-----------------------|---|------------------------------|------------|------------|--|
| 4. SOCIAL SECURITY NUMBER | | 5. SEX | 6. AGE (In | | himb day) | 70// | 17/K | IF UNDER | 04 1100 | 7. DATE OF BIRTH | 3 | 90 | HPLACE (State or Foreign |
| | n _e n | 5. SEX | | 70 70 | YRS. | MONTH | DER 1 YEAR | | MIN. | (Month, Day, Year) | | Count | try) |
| 224-22-8525 98. FACILITY NAME (If not in | atitudian -b- | | | 70 | . 110. | 01-0 | TV 704- | OR LOCATI | ON 05 55 | March 29. | 1920 | Vii | rginia |
| | | | 1 - | | - | 90. C | / / | / | | and | D | - | 0. |
| So MA | CEDENT | NU T | tosi | 1170 | 71 | | 61 | INT | ON | | | 6. | COUNTY |
| 10a. STATE | 10b. COUNTY | Y | | | 10c. CIT | Y, TOW | N OR LOC | ATION | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland | Prince | e George | S | | Tem | Dle | Hil: | 1s | | | | | 1 YES 2 NO |
| 10e. STREET AND NUMBER | | | | | | | | of. ZIP COD | E | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| 5114 Sharon | Rd. | | | | | | | 2074 | 8 | | II | S.A | |
| 11. MARITAL STATUS | | 12. WAS DECEDER | T EVER IN | U.S. ARI | MED | 1 | | ECENDENT (| F HISPAI | NIC ORIGIN? (Specify Yes | | 14. RAC | E — American Indian, ik, White, atc. |
| 1 Never Married 2 X | | IF YES, GIVE | | | | | | S 2 NO | | n, Puerto Rican, etc.) y: | | Spec | alty: |
| 1922/00 | | l | | | | | | | | | | | white |
| 15. DEC (Specify on | EDENT'S EDU ly highest grade | completed) | | (GI | | work do | ne during n | TION nost of worki | ng | 16b. KIND OF BU | SINESS/IN | DUSTRY | |
| Elamentary/Secondary (| 0-12) | College (1-4 or 5 | +) | | | | u.) | | | Chalac | | o . | - |
| | Materia 1 :: | | | At: | tend | ent | | 40.110 | Lampa de la constantina della constantina della | Child C | | cent | er |
| 17. FATHER'S NAME (First, M | | | | | | | | | | ME (First, Middle, Malden | | | |
| Elmer Payr | | | | 1.2 | | الإسالية ا | | | _ | et E. McGe | | | |
| 19a. INFORMANT'S NAME (| | | | | | | | | | Route Number, City or Tow | | | |
| A. Bishop N | | | - | | | | | | | e Hills. M | | 2074 | |
| 20s. METHOD OF DISPOSIT | on 3 🗆 Rem | oval from State | | other pla | ece) | | | cernetery, crer | | | | | own, State |
| 4 Donation 5 Other | | CENSEE | Ma | ary. | Land | Vet | terar | and Addre | nete: | OIL ITY | ltenl | | |
| ET. SILVINGI UNE DISTUNERO | AF SENAICE FI | VEH3EE / | | 7 | | | | | | | 4308 | Sui | tland Rd. |
| 0 | 240 | 1 7 | eil | soer | _ | I | Kober | ct E. | Wil | nelm, Inc. | Suit | Land | , MD. 20746 |
| 23. PART I. Entar the d ahock, or h IMMEDIATE CAUSE (Fir disease or condition resulting in death) | ieart failure. | a. Acut | use on ea | ch lina | andi | ial | | erct | | th as cardiac or reap | iratory as | reet, | Approximate interval Between Onset and Death |
| Sequentially list condi- if any, leading to imme cause. Enter UNDERLY CAUSE (Disease or inje- that initiated events reaulting in death) LAS | diate /iNG ury | b. Coro | | CONSEC | ouence o | _γ ι)F): , | j di | Iseas | و | | | | years |
| PART ii. Other algnific | ent condition | na contributing to | deeth bu | it not r | recuiting | in tha | underlyi | ing cause | given in | Part I. 24s. WAS AM | | 24 | b. WERE AUTOPSY FINDINGS |
| Pept | ic ul | cer de | seas | se | | | | | | PERFO | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED 1 | TO MEDICAL | | | | | | 26. | PLACE OF I | DEATH (C | heck only one) | | | |
| EXAMINER? | | HOSPITAL: | □ FR/Outon | etlant 2 | . □ po₄ | | HER: | | | 6 Other (Specify) | | | |
| 27. MANNER OF DEATH | | 28a. DATE O | F INJURY | J | 28b. TII | WE OF | 28c. t | NJURY AT | -arcenice | 28d. DESCRIBE HOW | INJURY O | CCURED | |
| | Pending | | Day, Year) | | | JURY N | | WORK? | ₩ NO | | | | |
| 2 Accident 3 Suicide | Investigation | 28a, PLACE | OF INJURY | — At he | ome, farm. | street. | | | 7 | 281. LOCATION (Street | and Numb | er or Rumi | Route Number, |
| 4 Homicide | Could not be datarmined | building | , atc. (Speci | ffy) | | | | | | City or Town, State |) | | |
| CONDUCTION . | | | | | | | | | | e to the cause(s) and ma | | | (a) and menner as stated. |
| 296. SIGNATURE AND TITL | ie Ch | home | eke, | , 7 | mo | | | 29c. LIC | 3 4 | MBER / | 29d. DA | TE SIGNE | 6 90 |
| 6357 OX | on Hi | HO COMPLETED CA | Oxo | in f | 1 (1) | Print) | 0 | 20. | 745 | 5 | | / | / |
| 31. DATE FILED (Month, Day | '90 | 32. BEGISTE | Davidso | | indell | _ | | | | | | | |

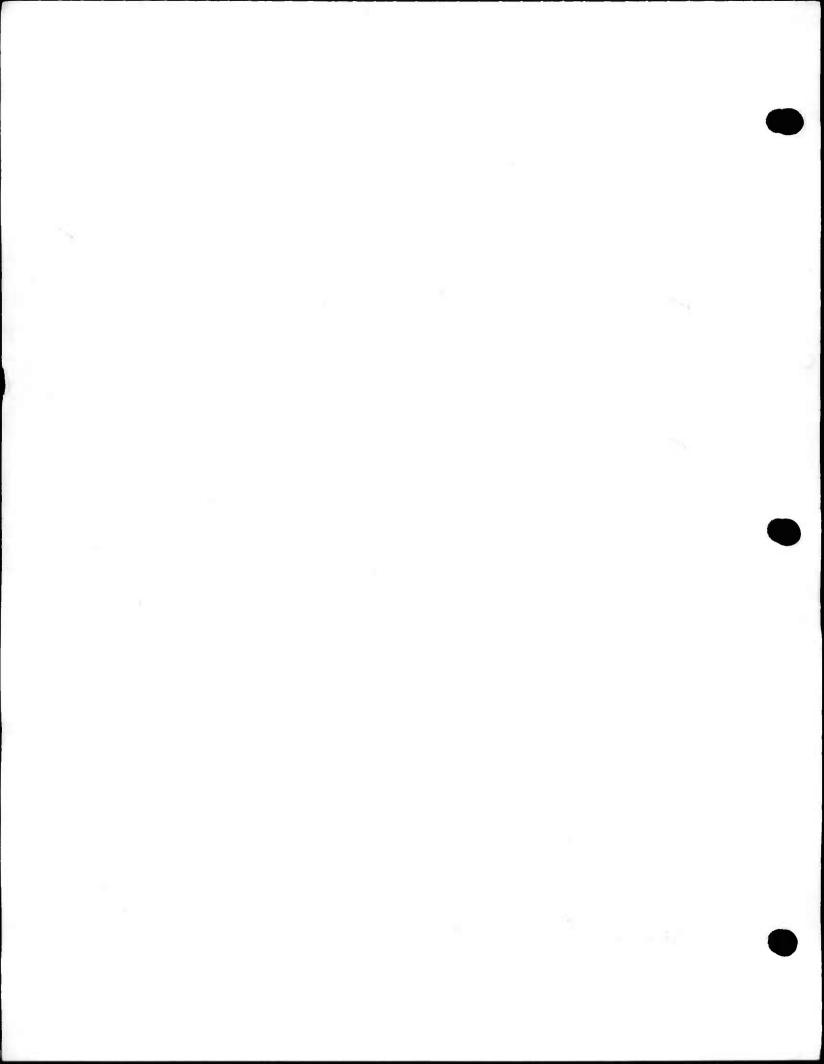
DHMH-16 Rev 1/89

r attending physician. use as the bunal-transit permit. Page: BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

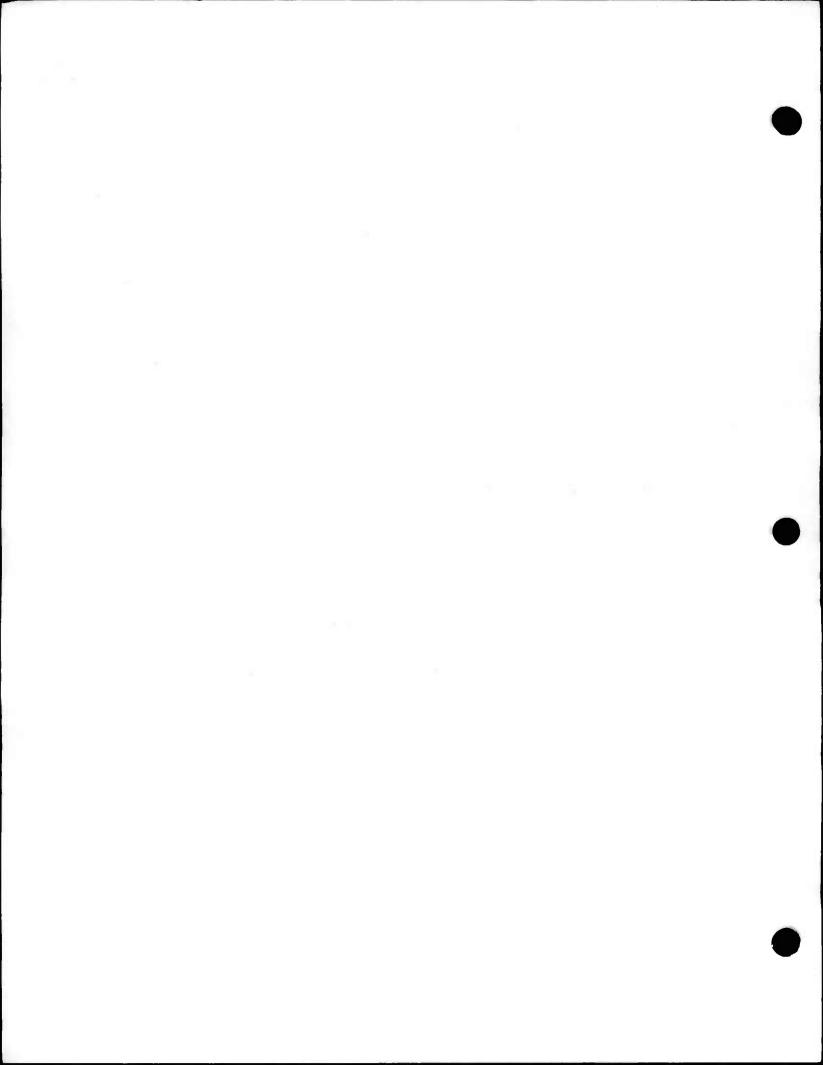
| TO BE COMPLET | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|--|--|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| he funeral director, page 5 should be detached for u | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for u |
| ir death. Page 6 may be retained by the hospital or | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 July after death. Page 6 may be retained by the hospital or |
| | |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM | | | MENTAL HYGIENE REG. NO. | | |
|----------------|--|---|---|-------------------|--------------------------------|--|-------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. OATE OF DEATH | / YEA | 3. TIME OF OEATH |
| | Margaret | L. | Mille | er | | 11/29/ | | M |
| | 4. SOCIAL SECURITY NUMBER | . / | MON | INDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. Bi | RTHPLACE (State or Foreign puntry) |
| | 220-22-1186 | 1 - M 2 F | 79 YAS. | - 00 | 55,170 | 12/24/10 | | MD |
| ~ | 9e. FACILITY NAME (If not institution, give str | reet and number) | 9b. | CITY, TOWN O | R LOCATION OF DE | ATH | 9c. COUNTY C | OF DEATH |
| DIRECTOR | 812 Ruxshire Dr | ive | | Arnold | | 1 | Anne | Arundel |
| မ္အ၂ | 10a. STATE 10b. COUNTY | | | WN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? |
| | MD Ann | e Arundel | Arno | old | | | | 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 812 Ruxshire Dr | ive | | 101. | ZIP CODE 210 | 11.2 | 10g. CITIZEN | OF WHAT COUNTRY? |
| W | 11. MARITAL STATUS | 12. WAS DECEDENT EVER II | A II S A DAMED | 12 WAS DEC | | IIC ORIGIN? (Specify Yea | | |
| BY FU | 1 Never Merried 2 Merried 3 Widowed 4 Divorced | FORCES? 1 YES | 2 NO | If yes, spe | 2 NO Specify | n, Puerto Rican, etc.) | 1 1 | IACE — American Indian, Black, White, atc. Specify: White |
| | 15. DECEDENT'S EOUC (Specify only highest grade of | | 16a. DECEDENT'S USU (Give kind of work | AL OCCUPATION | ON . | 16b. KIND OF BUS | INESS/INDUST | |
| COMPLETED | Elementery/Secondery (0-12) | College (1-4 or 5 +) | life. Do NOT use ret | ired.) | st or working | | | |
| M M | 12 | | Data Pr | ocessi | | Bankin | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NA | ME (First, Middle, Malden S | Sumame) | |
| H | Frances Marlon | Neighoff | | | | eth Schank | | |
| 2 | 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Town | , Stata, Zip Code |) |
| | Mrs. Elizabeth | | D. PLACE OF DISPOSITION | | | Arpold | CATION — City of | MD 21012 |
| | 1 Duriel 2 Cremetion 3 Remo | oval from State | other place) | | | | | or town, orace |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | Meadowridg | | ID ADDRESS OF FA | | ey, MD | TT |
| | ► (A) /// | (3 | | Dorron | ao Funor | | itchie | *** |
| | 23. PART /Enter the diseases, or c | complications that cause | d the death Do not | | | | | Park MD 21146 |
| | ehock, or heert fellure. I | Liet only one ceuse on e | ech line. | anter the mo | de of dying, edc | in es ceruiac or respir | etory erreat, | Interval Between Onset and Death |
| | IMMEDIATE CAUSE (Finel disease or condition | Condi | 5 Pulas | 10-11 | AKH | ELY | | Onset and Death |
| | resulting in deeth) | OUE TO (OR AS | A CONSEQUENCE OF): | any | /1-/-/- | 1 | | |
| z | | · (or | oncery | An To | en D | 1 tool | | |
| CERTIFICATION | Sequentielly liet conditions, if any, leeding to immediate | DUE TO (OR AS | CONSEQUENCE OF): | 1 | 1 1 | 1111111 | MI | |
| 2 | ceuse. Enter UNDERLYING CAUSE (Disease or Injury | a <i>C V</i> | nmic | ODF | Kullen | in Lung | VIK | an |
| E | thet initieted events | OUE TO (OR AS / | A CONSEQUENCE OF): | | | , | | |
| 띩 | | 1 | | | | | | |
| CAL | PART II. Other significant condition | | · // / | / | // 6 | Part I. 24a. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| | Demente | A cuit | y ASC | cock | 100 | 1 _ YES 2 | | COMPLETION OF CAUSE OF DEATH? |
| PHYSICIAN: MED | | | . 00 | | | | | 1 TES 2 NO |
| ä | | | | | | | | |
| CEA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | l or | 28. PL | ACE OF DEATH (Ch | eck only one) | | |
| YSI | 1 TES 2 NO | 1 Inpatient 2 ER/Out | patient 3 DOA 4 | Nursing Hom | | 8 - Other (Specify) | | |
| | 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIME OI INJURY | wo | RK? | 28d. DESCRIBE HOW II | NJURY OCCURE | D |
| BY | 2 Accident Investigation | 28a PLACE OF IN HIE | Y — At home, farm, stree | M 1 1 | | 28f. LOCATION (Street a | and Number or B | turni Doute Murchar |
| 윤 | 3 Suicide 8 Could not be 4 Homicide determined | building, etc. (Spe | clfy) | i, inclory, offic | • | City or Town, State) | ind trumbur of th | oral Florito Harrison, |
| COMPLETED | 290. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of my know | viedge, death accurred to | the time date | and place and du- | to the cause(s) and man | mer as stated | |
| MP | anal control (| R: On the beele of examination | | | | | | use(e) end manner as stated. |
| | 286. SIGNATURE AND TITLE OF CERTIFIES | | 7/ 1 | _ | 29c. LICENSE NUI | | | BNED (Month, Day, Year) |
| BE (| Axonali | 1 1/1 | realth |) | DO 8 | 293 | ► 12 | 13/90 |
| 5 | 30. NAME AND ADDRESS OF PERSON WH | | EATH (ITEM 27) (Type, Pri | | 2 | 11 | 2 | |
| | 31 RODIN | | ad VS | EVE | ina M | n//, m/ | 121 | 146 |
| | 31. DATE FILEO (Month), Day (Mar) Such | 32. REGISTRANT SIG | MOBE | | | | | |



| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremati IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, to BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|--|
| TO THE HOSPI TO THE FUNEF be filed within IMPORTANT: O BE CO |

| | 1 - STATE REGISTRAR | C | ERTIFI | CATE O | F DEATH | RE | EG. NO. | | | | |
|---------------|--|---|-------------------|--|--|--|---------------------------|-------------------|-------------------|--|----------------|
| | 1. DECEPÉNTS NAME DOS MOSS AND SE LA COMPANIA DEL COMPANIA DE LA COMPANIA DE LA COMPANIA DEL COMPANIA DE LA COM | | LEE | MEYE | | 2. DATE OF D | - | 90 | YEAR 90 | 3. TriME OF DIPATH | 2 _M |
| | 214-07-7893 | SEX 6. AGE In yrs. I | last birthday) | IF UNDER 1 YEAR | | 7. DATE OF B (Month, Day 8 - 7 - 1 | (, Year) | | Country | PLACE (State or Foreign yland | |
| DIRECTOR | 99. FACILITY NAME (If not institution, give street of Dorchester Gener RESIDENCE OF DECEDENT | | | es city, tow Cambr | i or Location of DE | ATH | | 9c. COUN | TY OF D | EATH | |
| <u> </u> | 10e. STATE 10b. COUNTY | | | TOWN OR LO | ATION | | | | | 10d. INSIDE CITY | \exists |
| | Maryland Dorche | ster | Can | nbrido | е | | | | | LIMITS? X YES 2 NO | |
| RAL | 10s. STREET AND NUMBER 105 Choptank Ave | | | | 21613 | | | USA | | HAT COUNTRY? | |
| BY FUNERAL | 11. MARITAL STATUS 12. | WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR DATES | NO | If yes, | ECENDENT OF HISPAN specify Cuben, Mexica ES 2 NO Specify | n. Puerto Rican | | | 14. RACE Black | — American Indian, White, etc. White | |
| COMPLETED | 15. DECEDENT'S EDUCATIC (Specify only highest grede comp Elementary/Secondary (0-12) Co | oleted) | | JSUAL OCCUPI ork done during retired.) | | 18b. KIN | D OF BUS | INESS/IND | | | |
| APL | 12 years | | ookke | eper | | Mun | ici | pal\ | Gr | ocory | |
| Ö | 17. FATHER'S NAME (First, Middle, Lest) | | | | 18. MOTHER'S NA | ME (First, Middle | e, Maiden S | Sumame) | , | | |
| BE | John H. Brannock 190. INFORMANT'S NAME (Type/Print) | | | | Euphro | | | | | | _ |
| 2 | William H. Meye | I | | | et and Number or Rural I | | | | | | |
| | 20a. METHOD OF DISPOSITION | 20b. PLAC | E OF DISPOSI | NODE a | nk Ave. | Cambr | | e M CATION — (| | | |
| | N Buriel 2 → Cremation 3 □ Removal 4 □ Donetion → □ Other (Specify) | from State O1d | Trin | ity C | huchyard | a l | Chu | rch | Cre | ek, Md. | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENS | 1 | | 22. NAME | AND ADDRESS OF FA | CILITY | | | | | |
| | Kennett & St | Lowes of | | 700 | Locust | St. C | amb | ridg | e, | Md. 2161: | 3 |
| | 23. PART I. Enter the diseases, or compandock, pr heart failure. Liet iMMEDIATE CAUSE (Finel disease pr condition | Dnly Dne cause Dn each ii | ne. | | node of dying, auc | h ea cerdlac | or reapir | ratory err | est, | Approximate Interval Betwee Onset and Dea | |
| 2 | resulting in death) a | DUE TO (OR AS A CONS | rovasc | ular | coident | | | | | | |
| CATIO | if env. jeading to immediate | DUE TO (OR AS A CONS DUE TO (OR AS A CONS DUE TO (OR AS A CONS | SECUENCE OF |): Rest | iratory f | ailure | | | | | |
| CERTIFICATION | that initieted events reculting in death) LAST | Breast C | CON CIP | Bre | ast carci | noma | | | | | |
| 0 | PART ii. Other significent conditions co | ontributing to death but no | t resulting is | n the underly | ing cause given in | Pert i. 24a | . WAS AN | | 24b | . WERE AUTOPSY FINDING |)S |
| DICAL | malnuttition | , renal failu | reure | dis | dissemina | ted 1 | PERFOR | | | AVAILABLE PRIDR TO COMPLETION OF CAUSE DF DEATH? | |
| M | intravascular co | oagulation, | pneumo | ennon mia | 19 | | | | | 1 YES 2 NO | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | OSPITAL: | | 26 OTHER: | PLACE DF DEATH (Ch | eck only one) | | | | | _ |
| YSI | 1 YES 2 NO 1 E | Inpatient 2 - ER/Outpatient | 3 DOA | 4 Nursing I | ome 5 - Residence | | | | | | _ |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 28b, TIME INJU | JRY | INJURY AT WORK? YES 2 NO | 28d. DESCRIE | BE HOW IN | NJURY OCC | CURED | | |
| | 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY — Al building, etc. (Specify) | home, farm, s | treet, factory, o | ffica | 281. LOCATIO City or To | N (Street a wn, Stete) | and Number | or Rural I | Route Number, | |
| COMPLETED | one) 2 MEDICAL EXAMINER: O | t: To the best of my knowledge, in the basic of examination and/ | or investigation | n, in my opinio | , death occured at the | Ilma, date and | place, en | d due to Ih | e ceuse(e | | |
| BEC | 29b. SIGNATURE AND TITLE OF CENTIFIER | - MITT | | | 29c, LICENSE NUI | MBER 749 | | 29d. DATI | SIGNED | (Month, Day, Year) | |
| 5 | 30. NAME AND ADDRESS OF PERSON WHO CO | DMPLETED CAUSE OF DEATH (I | TEM 27) (Type, | Print) St. (| Cambria | las r | m0 | ,, | 2/6 | 3 | |
| | 31. DATE FILED (MODID- Day, 1907) 3 '90 | 32. REGISTIANS SIGNATURE | son-Ran | delle | | / / | | | | | |



11+1Va

31. DATE FILED (Month, Day, Year)

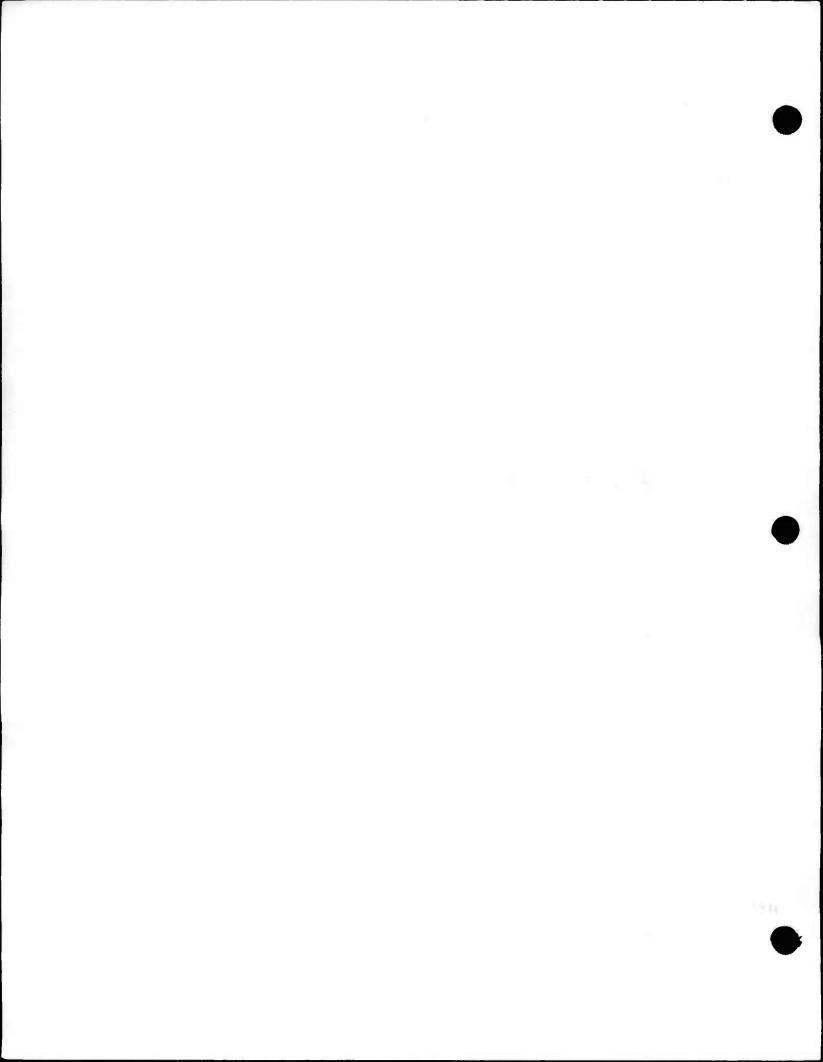
| | - | - |
|---|--|---|
| | 23 | J. |
| | iges 1 | |
| | his certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages to with the State hent of Health and Mental Hyplene prior to burial, cremation, or removal. | |
| | perm | |
| an. | ransit | |
| ttending physici | urial-I | |
| ing pl | the b | |
| ittend | as as | |
| I or | or us | |
| ospita | thed | as |
| the th | detac | OUC |
| À P | ed be | d at |
| taine | shou | tiffe |
| be re | ge 5 | e no |
| шау | or, pa | ust b |
| age 6 | direct | E |
| E. P. | neral | - Lu |
| e des | he fu | еха |
| s afte | remov | dlea |
| HOU | illed ir | e me |
| HYSICIAN: The law requires that the death certificate be executed within 24 nours after death, Page 6 may be retained by the hospital or attr | nation | t, th |
| d wit | I. crei | even |
| ecute | und co | atic |
| be ed | clan a | raum |
| ficate | physi ne pri | ner ti |
| certi | Hvale | or oth |
| death | ental | 17, |
| at the | by th | 三 |
| es the | gned afth | s an |
| requir | sen si | show |
| WE! | Dent De | 23 |
| The | State | Item |
| SICIA | certifi | 6 |
| ο_ | T this | marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| DING | R: After | S |
| TTEN | CTOR: | 28 |
| 0R / | THE FUNERAL OIRECTOR: | MPORTANT: If Item 28 Is m |
| PITAL | ERAL 0 72 | T. If |
| HOS | FUN | HAN |
| THE HOSPITAL OR ATTENDING | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the 1 has flux within 72 hours after death with the State Dent of Health and Merial Hydlene prior to burial, cremation, or removal. | MPO |
| _ | - 5 | - |

| | FOR 1 - STATE REGISTRAR | STATE OF N | IARYLAND / CE | | | T OF H | | | AENTA | AL HYGIENI REG. NO. | | 90 | 34455 |
|-------------|--|---------------------------|----------------------------------|------------------------------------|-------------|----------------|--------------------|------------|----------|----------------------------------|--------------|---|--|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | E OF OEATH | | 3. | TIME OF DEATH |
| | William Jacol | b Nort | h | | | | | - 1 | MON. | | 990 | YEAR | 5:00 PM |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. less | birthday) | IF UNDER | | IF UNDER | 24 HRS. | 7. DATE | E OF BIRTH | | | ACE (State or Foreign |
| | 214-07-8019 | 1XXM 2 □ F | 80 | YRS. | MONTHS | DAYS | HOURS | MIN. | De | c 17,1 | 909 | Country) | mbridge |
| | 9a. FACILITY NAME (If not institution, give st | | | | 9b. CITY | r, TOWN O | R LOCATIO | ON OF DE | | , | | TY OF DEAT | |
| œ/1 | William Hill I | Health | Care Ce | ente | r | Camb | orid | αe | | | Do | arche | ester |
| ECTOR | RESIDENCE OF DECEDENT | | | | | | | . 50 | | | | 71 011 | 30001 |
| E. 4 | 10s. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN | OR LOCAT | ION | | | | | 10 | d. INSIDE CITY LIMITS? |
| DIR | | rcheste | r | | Cam | brid | lae | | | | | 1 | ☐ YES 2X NO |
| 4 | 10e. STREET AND NUMBER | | | | | 10f. | ZIP CODI | E | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| FUNERAL | 5317 Bucktown | Road | | | | | 21 | 613 | | | J | JS | |
| 5 | 11. MARITAL STATUS | 12. WAS OECEDEN | T EVER IN U.S. AR | | 13. | WAS DECE | ENDENT C | F HISPAN | IC ORIG | IN? (Specify Yas Rican, atc.) | or No- | 14. RACE — | - American Indian, Vhite, etc. |
| BY F | 1 Never Merried 2 Married 3 Wildowed 4 Divorced | IF YES, GIVE W | | | | | | Specify. | | ricari, atc.) | | | White |
| | | WW | | | i | | | | | | | | |
| 핕 | 15. DECEDENT'S EDUC (Specify only highest grade | | (Gi | CEDENT'S ve kind of Do NOT u | work done | during mos | IN st of workin | ng | :16 | b. KIND OF BUS | INESS/INDU | STRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5 + | ·) | | | | | | | 22.20 | inata | | ntractor |
| COMPLETED | 11 | | Р. | lumb | er | | | | | | | 3 60 | ntractor |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | , Middle, Malden | | | |
| 핆 | George Washin | ngton | North | | | | | | | Elizak | | | ıth |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | mber, City or Town | | | 4.640 |
| | Pauline North | | _ | | | | | | Cam | bridge | | | |
| 1 | 20a METHOD OF DISPOSITION 1 Parties 2 Cremation 3 Ramo | oval from State | 20b. PLACE other pla | ice) | | | - | | | | CATION — C | | |
| | 4 Donation 5 Other (Specify) | | _ Md. | Vet | era | ns (| Ceme | ter | У | Ηι | irloc | ck, l | Md. |
| 1 1 | 21. SIGNATURE OF FUNERAL SERVICE LIC | | 1 | | 22. | NAME AN | ID ADDRE | SS OF FAC | CILITY | homas | Fune | eral | Home |
| | · Kennth A | Mon | us y. | | 7 | 00 I | cocu | st 8 | St. | Cambr | idge | e, Mo | d. 21613 |
| | 23. PART i. Enter the disease, or o | | | | not ente | r the mo | de of dy | ing, suct | h ee ce | rdiec or reepi | ratory erre | st, | Approximate |
| 1 1 | ehock, or heert feliure. | List only one cau | ise on each line | | | | | | | | | | interval Batween Onset and Death |
| | iMMEDIATE CAUSE (Final disease or condition | Hanir | or hay | 24 | 0. | U.1. |) (| | | | | | 2 utc |
| | resulting in deeth) | | (OR AS A CONSEC | | | | | | | | | | 7 3 |
| - | | | | | | | | | | | | | |
| RTIFICATION | Sequentielly liet conditione, if any, leeding to immediate | b DUE TO | (OR AS A CONSEC | DUENCE O | F): | | | | | | | | |
| § | ceuse. Enter UNDERLYING | e. | | | | | | | | | | | |
| 直 | CAUSE (Disease or injury that initiated evente | DUE TO | (OR AS A CONSEC | OUENCE O | F): | | | | | | | | |
| | resulting in death) LAST | d | | | | | | | | | | | |
| 2 | PART II Other significant condition | a contributing to | death but not - | noultino. | in the | n dia dula a | | mban to | Dort I | Total Mag and | ALFRODRY | 1 aas iii | PER ALTTORON FINISHOO |
| I₹I | PART II. Other significent condition | e contributing to | deeth but not r | esuiting | m uie u | nuerrymę | y cause | given in | Part I. | 24s. WAS AN PERFOR | | A | VERE AUTOPSY FINDINGS VAILABLE PRIOR TO OMPLETION OF CAUSE |
| EDICAL | - | | | | | | | | | 1 TYES 2 | □ NO | | F DEATH? |
| Σ | | | | | | | | | _ | | | 1 | TYES 2 NO |
| ż | | | | | | | | | | | | | |
| SICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHE | | ACE OF D | EATH (Che | eck only | one) | | | |
| IS | 1 YES 2 NO | 1 🗆 Inpetient 2 🗆 | ER/Outpatient 3 | □ DOA | | | e 5 □ R | esidence | 8 🗆 Oti | her (Specify) | | | |
| PHY | 27. MANNER OF DEATH | 28e. DATE OF (Month, D | | 28b. TIN | ME OF | 28c. INJ WO | URY AT | | 28d. D | EŞCRIBE HOW I | NJURY OCC | URED | |
| E E | 1 Natural 5 Pending 2 Accident investigation | | | | М | 1 🗆 1 | /ES 2 [| □ NO | | | | | |
| | 3 Suicide 8 Could not be | 28e. PLACE O building, | of INJURY — At he etc. (Specify) | me, farm, | street, fac | ctory, office | • | | | CATION (Street a | and Number | or Rural Rou | ite Number, |
| | 4 Homicide determined | | | | | | | | | | | | |
| 밀 | 29a. CERTIFIER (Check only | CIAN: To the best of | my knowledge, de | ath occur | red at the | time, data | and place | , and dua | to the c | cause(a) and mar | ner as state | d. | |
| W | one) 2 MEDICAL EXAMINE | R: On the basis of e | xamination and/or | Investigati | on, In my | opinion, d | leath occu | red at the | time, da | its and place, an | d due to the | cause(a) a | ind manner as ateted. |
| S E | 29b. SIGNATURE AND TITLE OF CERTIFIE | R > | | | | | 29c. LIC | ENSE NUN | MBER | | 29d. DATE | SIGNED (N | fonth, Day, Year) |
| 100 | milte | alele | CZ N | 10 | | | 1) | 26. | 38 | 5 | D // | 1/27 | 190 |
| 일 | 30, NAME AND ADDRESS OF PERSON WH | J- C | | M 27) (Tm | e Print) | | | | | , , | | (· · · · · · · · · · · · · · · · · · · | |

2164

32 REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89



TO THE HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22-mous after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

IMPORTANT: It lem 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

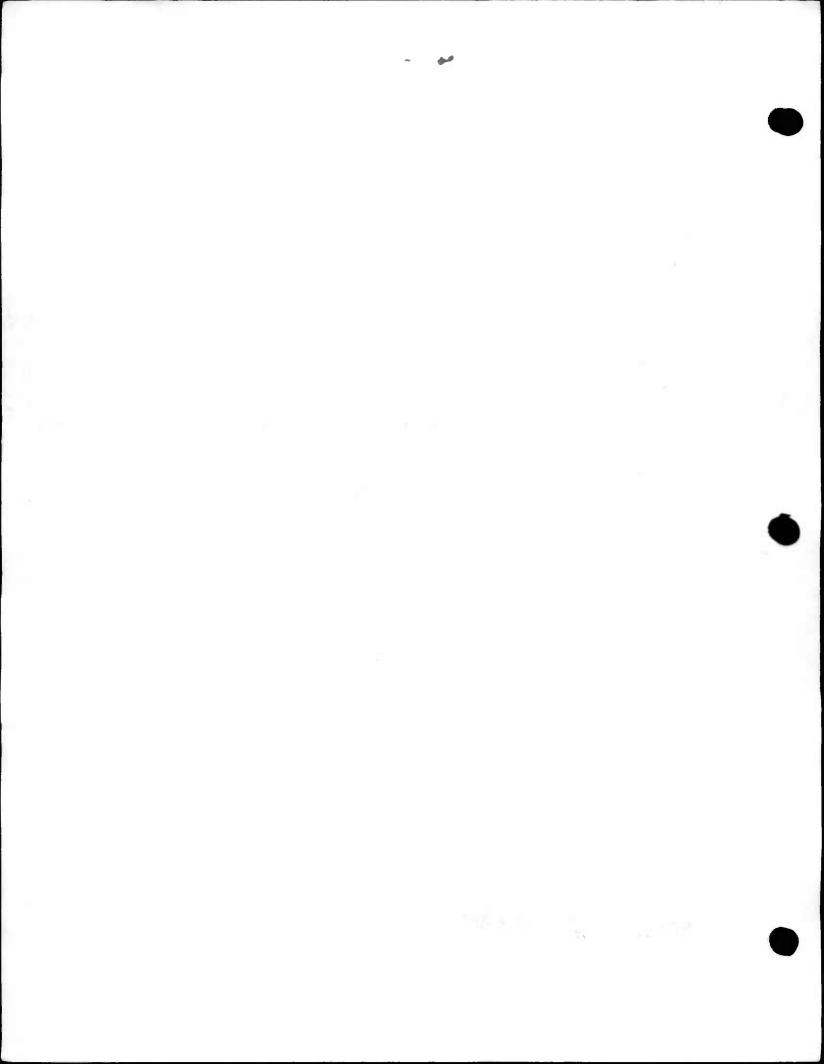
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO BE COMPLETED BY FUNERAL DIRECTOR

34456 9 N

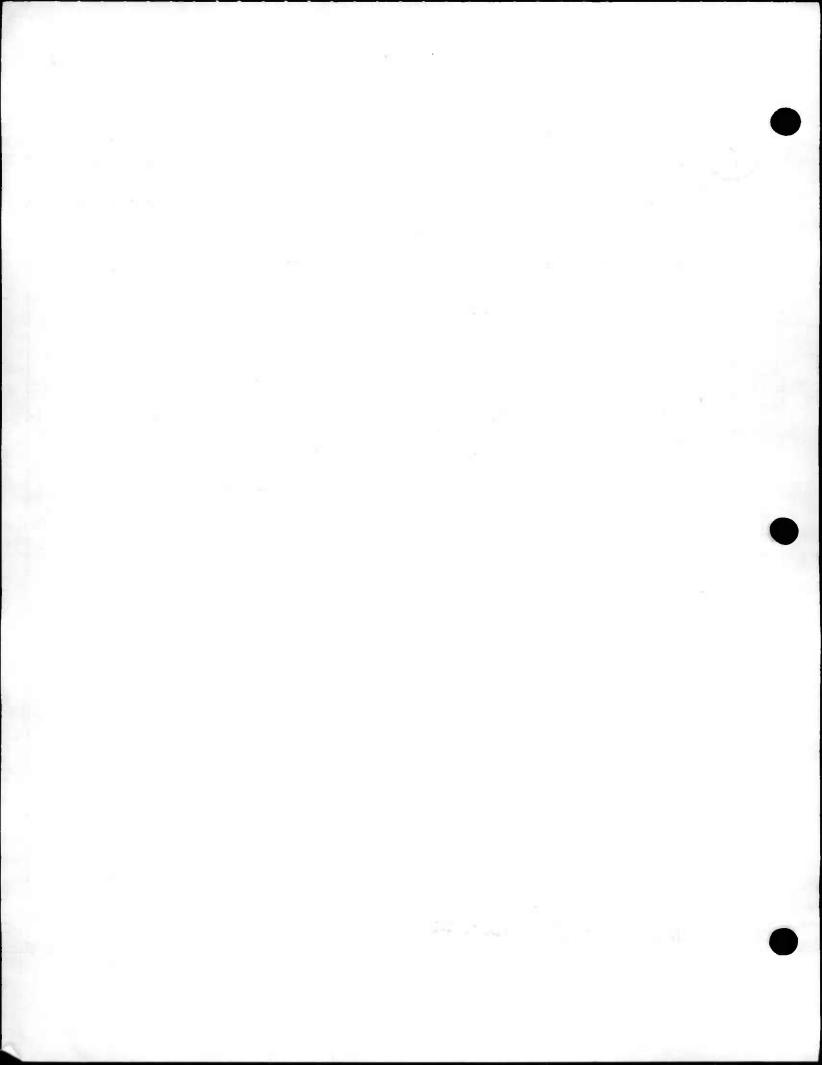
| 1 - FOR STATE REGISTRAR | STATE OF MARYL | AND / DEPARTM CERTIFIC | | | MENTAL HYGIENI REG. NO. | 90 | 34456 |
|--|---|---------------------------|---------------------|-----------------|---|------------------|--|
| 1. OECEOENT'S NAME (First, Middle, Last) | - | 27.7 | | | 2. DATE OF DEATH MONTH 26-90 | Y YEAI | 3. TIME OF DEATH 1:43PM |
| Alex 4. SOCIAL SECURITY NUMBER 5 | | Ne1 | | F UNDER 24 HRS. | 7. DATE OF BIRTH | | T. 43PM M |
| | □ M 2 ☑ F 1 | | | DURS MIN. | (Month, Dey, Year) 07/09/8 | Co | untry) |
| 9a. FACILITY NAME (If not inatitution, give stree | t and number) | 9b | L CITY, TOWN OR I | OCATION OF DE | | 9c. COUNTY O | |
| Greater Laurel Bel | ltsville Ho | spital | Laure | el | | Prince | Georges Co. |
| 10 e. STATE 10b. COUNTY | | 10c. CiTY, TO | OWN OR LOCATION | 1 | - | | 10d. INSIDE CITY LIMITS? |
| | RUNDEL | ANNA | POLIS | | | | YES 2 NO |
| 13819 Briarwoo | od Drive | | | 0707 | | USA | F WHAT COUNTRY? |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 2. WAS DECEDENT EVER IF FORCES? 1 YES IF YES, GIVE WAR OR O | 2-ENO | If yea, specif | | IC ORIGIN? (Specify Yee n, Puarto Ricen, atc.) | 8 | ACE — American Indian, lack, Whita, atc. pecify: WHITE |
| 15. DECEDENT'S EDUCAT (Specify only highest grade co | | 16a. DECEDENT'S USI | done during most of | of working | 16b. KIND OF BUS | INESS/INDUSTR | Y |
| | College (1-4 or 5+) | life. Do NOT use re | rared.) | | 37./4 | | į |
| N / A 17. FATHER'S NAME (First, Middle, Last) | | N/A | 1 | 8. MOTHER'S NAI | ME (First, Middle, Maiden | Sumame) | |
| WESLEY NELSON | | | | | A LEE | | |
| 19e. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or Tow | | |
| GLENDA NELSON | | | | | RIVE LAU | REL. 1 | 1D APt. 1014 |
| 20a. METHOD OF DISPOSITION 1 Burial 2 □ Cremation 3 □ Ramovi 4 □ Donation 6 □ Other (Specify) | al from State | other place) | | | | CATION — City o | |
| 21. SIGNATURE OF PUNERAL BENVICE LICEN | ISEE, | AKEWOOD_ | | ADDRESS OF FA | CILITY | | LE, MS |
| · batt & C | all | | | | IERAL HOM S ROAD. | | |
| | st only ona cause on a | ach Ilna. | | | | | interval Between Onset and Death |
| Sequentielly list conditions, if eny, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | | A CONSEQUENCE OF): | | | | | |
| PART II. Other significant conditions | contributing to death t | out not resulting in t | tha underlying o | ause given in | Part I. 24a. WAS AN PERFOR | IMED? | 24b, WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? YES 2 \(\sqrt{N} \) NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | E OF DEATH (Ch | eck only one) | | |
| 1∑SYES 2 □ NO | ☐ Inpatient 2 ② ER/Out | petient 3 DOA 4 | | | 6 Other (Specify) | | |
| 27. MANNER OF DEATH 1 🔀 Natural 6 🗌 Pending | 26a. DATE OF INJURY (Month, Day, Year) | 28b. TIME C | Y WORK | | 28d. DESCRIBE HOW I | NJURY OCCURE | D |
| 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJURI building, etc. (Spe | Y — At home, farm, stre | | 2 10 | 28f. LOCATION (Street City or Town, State) | snd Number or Re | iral Route Number, |
| (Critica Orlly | AN: To the best of my know On the basis of examination | | | | | | ise(a) and manner as stated. |
| 206. SIGNATURE AMENTICLE OF CERTIFIER | // | | : | 9c. LICENSE NUI | MBER | 29d. DATE SIG | NED (Month, Day, Year) |
| tille | | | | OCME | | ▶ 11· | -27-90 |
| 30. NAME AND ADORESS OF PERSON WHO | COMPLETED CAUSE OF DI | | | | | | 201 |
| FRANK PERETTI, MD | Kanada Bud | - 100 | 111 Penn | Street | ,Baltimore | ,MD 21 | 201 vo |
| 3/10V" 2 9" 1990" Julia | A SPANION MARIE SIGI | NATURE | | | | | |



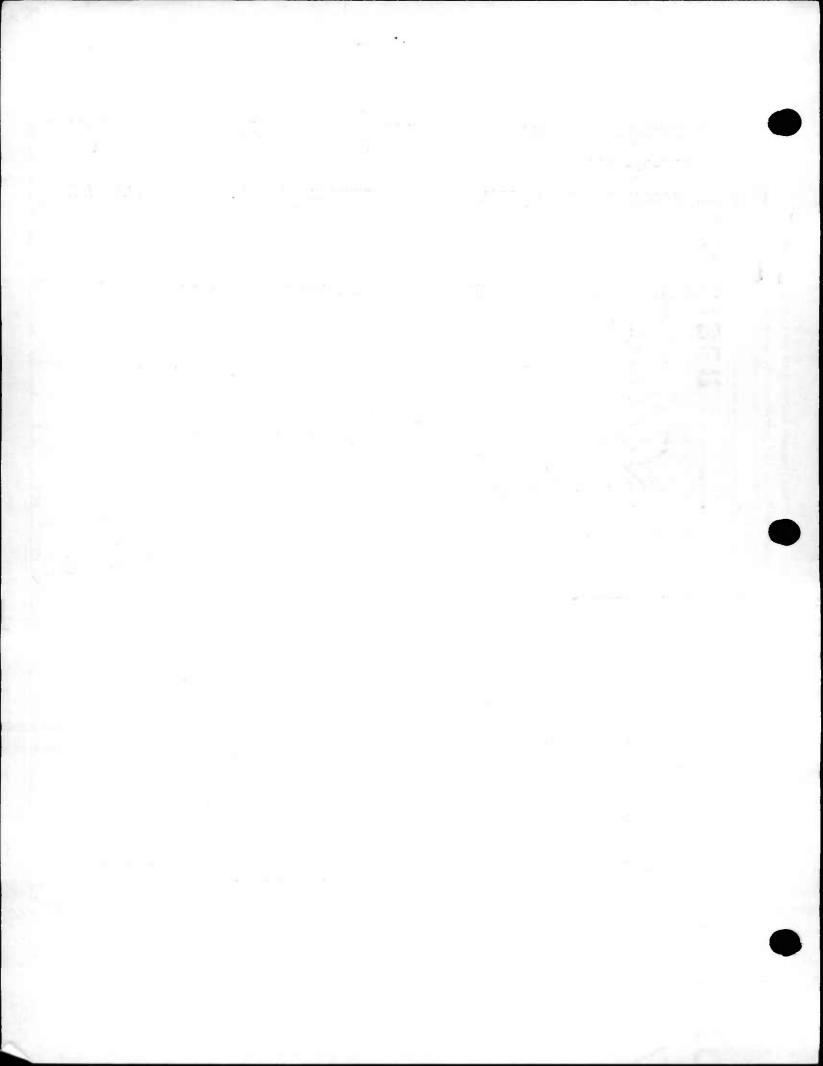
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a now after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sho be filled within 72 hours after death with the State Dept, of Health and Mental Hyglene prior to burial, cremation, or removal. IMPORTANT: If them 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|
|--|

31. DATE FILED (Month, Day, Year) NOV 27 1990

| | | | | | | | |) | U | 4401 | | |
|-------------------|---|--|----------------------------------|------------------|--------------------|--------------------|---------------------------|-------------|----------------|------------------------------|--|--|
| | FOR STATE REGISTRAR | STATE OF MA | | PARTMENT | | | MENTAL HYGIEN REG. NO. | E | | | | |
|) | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | v | YEAR 3. TI | ME OF DEATH | | |
| | WILFRED E | 3. | | NAGLE | | | 11 23 | | | 6 AM M | | |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. | AGE (In yrs. last birtho | day) IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | _ | a. BIRTHPLAC | E (State or Foreign | | |
| | 578-46-7206 | 1 🖾 M 2 🗆 F | 56 YR | | DAYS | HOURS MIN. | 01-26-34 | _ | | Branch, No | | |
| ~ | :1 | | | | | | ATH | 9c. COUN | ITY OF DEATH | | | |
| DIRECTOR | NORTH ARUNDEL HOS | PITAL ASS | OCIATION | GI | EN E | BURNIE | | <u> </u> | A. CO | UNTY | | |
| Ä | 10a. STATE 10b. COUNTY | f | 10c. | CITY, TOWN | OR LOCATI | ION | | | 10d. | INSIDE CITY LIMITS? | | |
| | | ARUNDEL | ı G | AMBRI | | | | | 1 🗆 | YES X NO | | |
| FUNERAL | 100. STREET AND NUMBER 869 FROST VALL | V CTDCIE | , | | | ZIP CODE | | | ZEN OF WHAT | COUNTRY? | | |
| N I | 11. MARITAL STATUS | 12. WAS DECEDENT E | | 1.0 | | 21064 | IIC ORIGIN? (Specify Yes | USA | | | | |
| | 1 Never Married 2 Married | FORCES? 1 | YES 2 NO | 1.0 | If yes, spe | city Cuban, Mexica | n, Puerlo Rican, atc.) | or No- | Black, Whi | merican Indian, ita, aic. | | |
| B | 3 Widowed 4 Olvorced | IF YES, GIVE WAR | OR DATES | | 1 TYES | 2 NO Specify | r: | | Specify: | | | |
| E | 15. DECEDENT'S EDUC (Specify only highest grade | | | NT'S USUAL O | | | 16b. KIND OF BU | SINESS/IND | USTRY | HITE | | |
| COMPLET | Elementary/Secondary (6-12) | College (1-4 or 5+) | Ille. Do N | OT use retired.) | ourng mod | n or working | | | | | | |
| MP | 11 | | PRI | NTER | | | | | POST | NEWS. | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) WILFRED A. N | (ACT E | | | | | ME (First, Middle, Malden | | | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | AGLE | T 405 MAI | 1 110 400050 | 2.40 | | IY C. FOR | | | | | |
| 5 | DOROTHY C | . NAGLE | | | | | RCLE, GA | | | MD 21064 | | |
| | 20s. METHOD OF DISPOSITION 1 Donation 5 Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place) MARYLAND NATIONAL MEM PK LAIREL MD | | | | | | | | | | | |
| | 4 Donetton 5 Other (Specify) AMARYLAND NATIONAL MEM PK LAUREL, MD 21. SIGNATURE OF FUNERAL HOME, P. A | | | | | | | | | | | |
| | * Datt & | bullh | | 8 | 51 | ANNAPOL | IS ROAD, | GAM | BRILL | S, MD | | |
| | 23. PART I. Enter the diseases, or of shock, or heart fellure. | | | Do not antar | the mo | da of dying, suc | h as cardiec or resp | iratory arm | est, | Approximete interval Between | | |
| | immediate cause (Final disease or condition Brain Dead | | | | | | | | ł | Onset and Death | | |
| | reaulting in death) | DUE TO (OF | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | |
| N | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING ONICE OF SA CONSEQUENCE OF: DUE TO (OR AS A CONSEQUENCE OF): HY DO K (A CROSS CHIEF OF CONSEQUENCE OF): HY DO K (A CROSS CHIEF OF CONSEQUENCE OF): | | | | | | | | | | | |
| ATI | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): UNDERLYING DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events | c. OUE TO (OF | R AS A CONSEQUEN | 7-00 | | | - | | | | | |
| FE | resulting in death) LAST | · Seve | ne 61 | and | (D) | yası | w. | | | | | |
| 2 | PART ii. Other aignificant condition | a contribution to de | ath but not moule | ine in the | and a selection of | - course shows to | B-di la year | | 1 | E AUTOPSY FINDINGS | | |
| 3 | PART II. Other aignitions condition | a contributing to de | sacir but not resum | mig in the di | Idenying | I canse diveir in | PERFO | | AWAI | LABLE PRIDR TO | | |
| ă | · | | | | | | 1 YES : | R □ NO | | DEATH? | | |
| Z | | | | | | | - | | 1 🗆 | YES 2 NO | | |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | 20 50 | ACE OF DEATH (Ch | | | | | | |
| PHYSICIAN: MEDICA | EXAMINER? 1 YES 2 NO | HOSPITAL: | R/Outpatient 3 Di | OTHE | R: | | 6 Other (Specify) | | | | | |
| HX | 27. MANNER OF DEATH | 26s. OATE OF IN | JURY 28b | TIME OF | 28c. INJ | URY AT | 28d. DESCRIBE HOW | INJURY OCC | CURED | | | |
| ВУ Р | 1 Natural 5 Pending | (Month, Day, | INJURY M | | RK? res 2 \[NO | | | | | | | |
| | 2 Accident investigation 3 Suicide 6 Could not be determined determined determined. 28s. PLACE OF INJURY A1 home, farm, street, factory, office 2st. LOCATION (Street and Number or R City or Town, State) | | | | | | | | or Rural Route | Number, | | |
| | 290. CERTIFIER | | | | | | | | | | | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINE | ICIAN: To the best of my ER: On the basis of exam | | | | | | | | I manner as stated. | | |
| BE | 296. SIGNATURE AND TITLE OF CERTIFIES | Red | dig 1 | 10 | | D375 | MBER 86 | 29d, DATI | E SIGNED (Mon | th, Day, Year) | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHEN SHOBHA D. REDDY M | O COMPLETED CAUSE | OF DEATH (ITEM 27) | (Type Print) | 201. / | 0 0 1 | | AND | 21061 | | | |
| - 1 | | | MILITARIO IN | UND # | 204/ | GLEN DUK | MIE, MAKIL | AND 2 | 1001 | | | |



| - STATE REGISTRAR | STATE OF MARYLA | OERTIFIC | | HEALTH AND MEDICAL PROPERTY IN THE PROPERTY IN | | REG. NO. | | | | |
|--|---|--|------------------------------|--|-------------------------------|--|--|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) SEYMOUR SH | ELL | NEALIS | 5 | | 2. DATE OF MONTH | 04 DAY | 90 YEAR | 3. TIME OF DEATH 02:11AM | | |
| | XXM 2 □ F 83 | YRS. | HUNDER 1 YEAR DAYS DAYS | IF UNDER 24 HRS. HOURS MIN. OR LOCATION OF OE | MIN. 8 972 9 19 0 7 | | | 8. BIRTNPLACE (State or Foreign | | |
| SACRED HEART H | W = 10 | | | BERLAND, | | | | LLEGANY | | |
| 10a. STATE 10b. COUNTY Maryland Garre | | | wanto | | | | | 16d. INSIDE CITY LIMITS? 1 YES 2 NO | | |
| Rt. 1 Box 181 | | | 10 | 21561 | | | USA | WHAT COUNTRY? | | |
| | 2. Was decedent ever in 1 Forces? 1 _ yes If yes, give war or dat | 2 X No | If yes, s | CENDENT OF NISPANI pocify Cuban, Maxican S 27 100 Specify: | , Puerlo Ric | Specify Yea or an, atc.) | No- 14. RA | CE — American Indian, ick, White, etc. | | |
| 15. DECEDENT'S EDUCAT (Specify only highest grade con Elementary/Secondary (0-12) | | (Give kind of won life. Do NOT use r | k done during rr etired.) | nost of working | | | co Par | | | |
| | Nealis | | | Mary | ME (First, Mid Jane | Gano | rname) | | | |
| Barbara Fisher | | 517 M | orris | end Number or Rural R on St. V | | rnpo | rt, Mo | | | |
| 20g METHOD OF DISPOSITION A Burlel 2 Cremetlon 3 Remove 4 Donation 6 Other (Specify) | | PLACE OF DISPOSITE Phil | os Ce | metery | | | ternpo | Town, State ort Md. | | |
| 21. SIGNATURE OF FUNERAL SERVICE LICENS | ral h. | | 22. NAME / | AND ADDRESS OF FAC Boal-War Western | rnick | | | | | |
| shock, or heert feliure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if sny, leading to immediate couse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST List only one cause on each line. Intendice of the course of the properties of the course of the c | | | | | | | | | | |
| PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. Drace of Color Dukes S S No 1 yes 2 NO 1 yes 2 NO 1 yes 2 NO 25. Was Case Reference of Medical Examiner? PART II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. 1 yes 2 NO 1 yes | | | | | | | | | | |
| 1 TYES 2 NO | Inpatient 2 □ ER/Outpe 28e, DATE OF INJURY | tient 3 DOA 4 | | IURY OCCUREO | | | | | | |
| 27. MANNER OF DEATH 1) Natural 5 Pending | (Month, Day, Year) | 11001 | M 1 | YES 2 NO | | LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | |
| | (Month, Day, Year) 28e. PLACE OF INJURY - building, etc. (Specil | — Al home, farm, str | | YES 2 NO | | | d Number or Run | af Route Number, | | |
| Natural 5 Pending Investigation 3 Suicide 4 Homicide Could not be determined | 28e. PLACE OF INJURY building, etc. (Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specific | — Al home, farm, stri | set, factory, off | ice | City or | Town, State) | er as stated. | | | |
| Neturel Neturel 5 Pending Investigation | 28e. PLACE OF INJURY building, etc. (Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specifical Specific | — Al home, farm, stn ly) odge, death occurred and/or investigation, | et, factory, off | ice | to the cause time, deta at | Town, State) | or as stated. dus to the caus 29d. DATE SION | | | |



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| BALTIMORE | donth |
| m | 200 |

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

9a. FACILITY NAME (If not institution, give street end number)

MARY/AND

4. SOCIAL SECURITY NUMBER

095-12-8330-A

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| DIREC | 100. STATE Maryland | 10b. COUNTY | ce George's | | own or Loca inton | ATION | | | | 1. INSIDE CITY LIMITS? YES 2 [X] NO |
|--|--|--|--|--|-----------------------|---|--|-----------------------------|-----------------|--|
| FUNERAL | 100. STREET AND NUMBER 8906 Marg | ne | <u>'-</u> | 101. ZIP CODE 10g. CITIZEN 0 20735-2722 U | | | | | ** | |
| B√ | 11. MARITAL STATUS 1 Never Merried 2 2 3 Wildowed 4 Divo | | 12. WAS OECEDENT EVER IN FORCES? 1 XXES IF YES, GIVE WAR OR DA | 2 NO | If yes, a | CENOENT OF HISPANI pecify Cuben, Mexicen S 2 XNO Specify: | C ORIGIN? (Specify Ye , Puerto Ricen, etc.) | or No— | Specify: | American Indian, hite, etc. |
| OMPLETED | | EDENT'S EOUC y highest grade 0-12) | completed) College (1-4 or 5+) | 16e. DECEOENT'S US (Give kind of work life. Do NOT use no Special E | done during natired.) | nost of working | 166. KIND OF BU | siness/ind | | |
| ш | 17. FATHER'S NAME (First, M August Hei | | | - | | | NE (First, Middle, Malden | | 10 | |
| 2 | 19a. INFORMANT'S NAME (1 | | k | | as 10 | | oute Number, City or Tov | vn, State, Zip | o Code) | Ting. |
| examiner must be | 20e. METHOD OF OISPOSIT 1 Deurier 2 Crematic 4 Donetion 5 Other 21. SIGNATURE OF JUNESA | on 3 🗆 Reme (Specify) | Ma | PLACE OF OISPOSITE other place) ryland St. | ate Ve | terans Ce | metery C | helte unera | al Home | Marylande, Inc. |
| CERTIFICATION | | dione, dileta | Suy | | anter the m | ed dying, such | as cardiac or reap | elratory an | reat, | Approximata interval Betwee Onset and Dast |
| snows any injury, or out : MEDICAL CERTI | resulting in death) LAS | - | a contributing to seath b | ut not resulting in | the underlyi | ng cause given in l | PERFO | N AUTOPSY RMED? 2 140 | AM CC DF | RE AUTOPSY FINDINGS AILABLE PRIOR TO IMPLETION OF CAUSE OEATH? YES 2 NO |
| SICIAN: | 25. WAS CASE REFERRED TEXAMINER? 1 YES 2 NO | O MEGICAL | HOSPITAL: | netlent 3 DOA 4 | THER: | PLACE OF OEATH (Che | | | | |
| BY PHY | 27. MANNER OF OEATH 1 Natural 5 | Pending Investigation | 26e. OATE OF INJURY (Month, Day, Year) | 26b. TIME (| OF 26c. II | NJURY AT YORK? YES 2 NO | 26d. DESCRIBE HOW | INJURY OC | CURED | |
| E C | 2 Accident Investigation 3 Suicide 6 Coyld not be defermined 26e. PLACE OF INJURY — A1 home, farm, street, fectory, office City or Rwn, State) 26f. LOCATION (Street and Number or Rural Route Number of Rural Route Numbe | | | | | | | | | e Number, |
| ANT: If Item 2 COMPLET | one) 2 MEC | PICAL EXAMINE | CIAN: To the best of my know | | | | | nd due 10 1 | lhe cause(e) ar | |
| TO BE COM | 29b. SIGNATURE AND TITLE | und | e mil | ATII 4700 | | 29c. LICENSE NUM | D23628 | 29d. DAT | TE SIGNED (M | onth) Day, Year) |
| | 7700 | d B | o completed cause of de | AIH (ITEM 27) (7/300) | nton | . W | | | • | |

32. REGISTRAR'S SIGNATURE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

DAYS

HOURS

CHINTON

9b. CITY, TOWN OR LOCATION OF DEATH

Nowak

6. AGE (In yrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS.

YRS.

Ruth L.

HOSPITAL

5. SEX

1 🗌 M 2 💢 F

90 34459

6. BIRTHPLACE (State or Foreign Country) New York

P.G. COUNT

YEAR 90

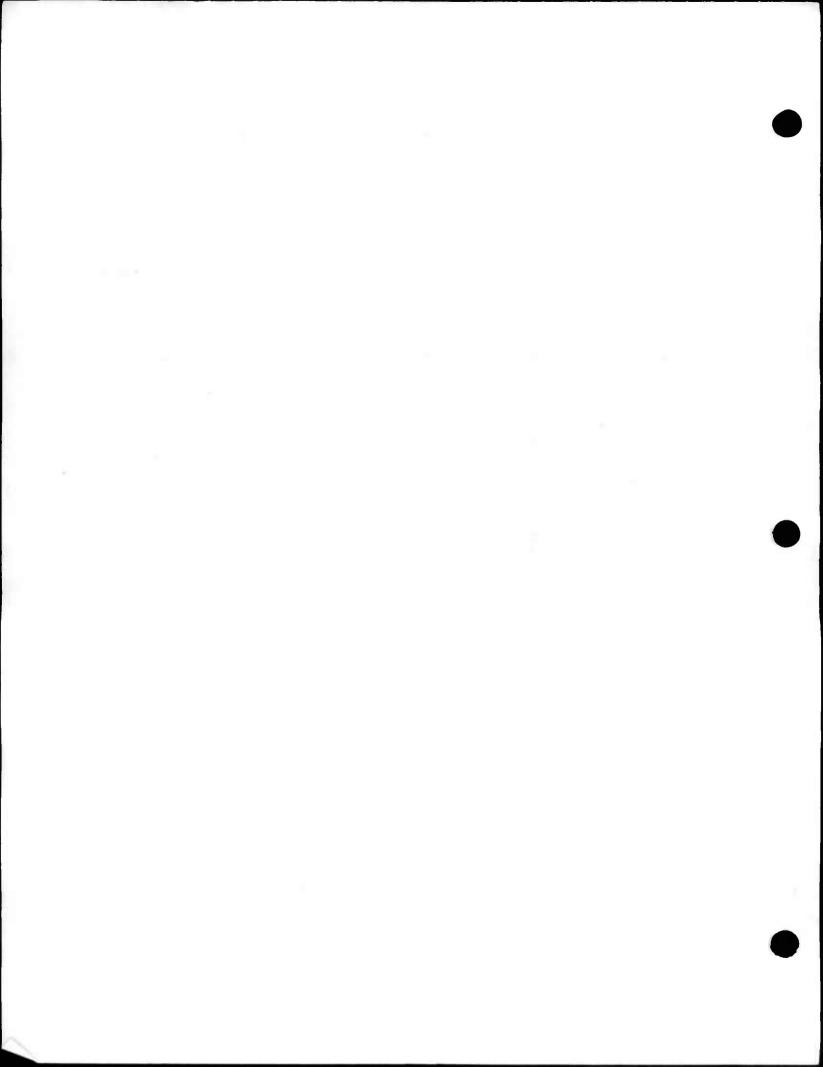
9c. COUNTY OF OEATH

2. DATE OF DEATH MONTH

7. OATE OF BIRTH (Month, Day, Year) 09 17

19

29d. DATE SIGNED (Month) Day, Year)



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| e hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It is not within 72 hours after death with the State Dent, of Health and Mental Hydlene prior to burial, cremation, or removal. | nce. |
|---|---|--|
| after death. Page 6 may be retained by the | by the funeral director, page 5 should be or moval. | ical examiner must be notified at o |
| ertificate be executed within a nours | ng physician and completely filled in t glene prior to burial, cremation, or re- | other traumatic event, the med |
| AN: The law requires that the death or | lificate has been signed by the attendil s State Deot. of Health and Mental Hw | r item 23 shows any injury, or |
| THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune find within 72 hours after death with the State Degl. of Health and Mental Hydlene prior to burial, cremation, or removal. | IMPORTANT. If item 28 is marked, or item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

| | | | | | | | | | | | 9 | 0 3 | 34460 |
|--------------------|--|----------------------|---------------------------|-------------|----------------------------|-------------|--------------|-----------|--------------|--------------------------------|--------------|--------------------------------|--------------------------------------|
| | FOR 1 - STATE REGISTRAR | STATE OF I | MARYLAND / | DEPAR | RTMENT | OF H | EALTH | AND I | MENTAL | | E | | |
| | 1. OECEOENT'S NAME (First, Middle, Last) | | CE | HIII | ICALL | · OF | DEAL | п | 2. DATE | REG. NO. | | 3. | TIME OF DEATH |
| | William P. Owens | | | | | | | | MONTH | mber 2 | × 190 | YEAR | 9:20 A. M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | t YEAR | IF UNDER | 24 HRS. | 7. OATE | OF BIRTH | | & BIRTHPL | CF (State or Foreign |
| | 577-80-8854 | 1 🔀 M 2 🗌 F | 30 | YRS. | MONTHS | DAYS | HOURS | MIN. | Feb. | 10.1 | 960 W | ashin | gton, D.C. |
| | 9a. FACILITY NAME (If not institution, give at | eet and number) | | | 9b. CITY | TOWN C | R LOCATIO | ON OF DE | | | | TY OF DEAT | |
| 5 | 130 Linden Ave. | | | | Edge | wate | r | | | | Anne | e Arui | ndel |
| DIRECTOR | RESIDENCE OF DECEDENT | | | | | | | | | | | | |
| E | 10a. STATE 10b. COUNTY | | | 10c. CIT | Y, TOWN C | R LOCAT | ION | | | | | | d. INSIDE CITY LIMITS? |
| 0 | Maryland Anne | Arundel | | Ed | gewa | | | | | | | | YES 2 NO |
| FUNERAL | | | | | | 101 | ZIP CODE | | | | 10g. CITIZ | EN OF WHA | T COUNTRY? |
| W | 130 Linden Ave. | 40.000.000.000 | NT EVER IN U.S. AR | | | | 2103 | | | | | S.A. | |
| | 1 Never Merried 2 Married | FORCES? | TES 2 VA | IO | 1.3 | If yes, spi | cify Cube | n, Mexica | n, Puerto F | ? (Specify Yes lican, etc.) | or No- | Black, W | American Indian, hite, etc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE | WAR OR DATES | | | 1 🗌 YES | 2 × NO | Specify | y: | | | Specify: | white |
| | 15. OECEDENT'S EDUC (Specify only highest grade | | 16a. DE | CEOENT'S | USUAL O | CCUPATIO | N | | 16b. | KIND OF BUS | SINESS/IND | | |
| ᇤ | Elementary/Secondary (0-12) | College (1-4 or 5 | +) Iffe. | Do NOT u | work done ise retired.) | auring mo | st of workin | 9 | | | | | |
| 릴 | 12 | -1741 | Bar | tend | ler | | | | | Restau | ırant | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 18. MOTH | IER'S NA | ME (First, A | Middle, Maiden | Surname) | | |
| BE (| Elmer E. Owens | | | | | | | ry E | _ | | | | |
| 2 | 196. INFORMANT'S NAME (Type/Print) | | | | | | | | | ber, City or Town | | | |
| | Mary Howard | | | | _ | | | | er Ma | rlboro | | | |
| | 20a. METHOD OF DISPOSITION 1 □ Burial 2 □ Cremation 3 □ Remo | rval from Stata | 20b. PLACE other pla | nce) | | | | | | | | City or Town, | Stata |
| < | 4 Donation 5 Other (Specify) | PANE (| L_Ceda | r Hi | 11 Ce | | D ADDRES | | CII (TV | . I Sui | t.land | , | |
| 1 | 12 | 7 | 1 | | | | | | | | 4308 | 8 Suit | cland Rd. |
| | Deya | 1/h | eban | | R | ober | t E. | Wil | Lhelm | , Inc. | Sui | tland | , MD.20746 |
| | 23. PART I. Enter the dispases, or c shock, or heart fallure. | omplications th | at caused the de | ath. Do | not enter | the mo | de of dy | ing, suc | h aa card | flec or reepi | ratory arr | oat, | Approximate interval Between |
| - 1 | IMMEDIATE CALICE (MAN) | | | | | ^ | , | | | | | | Onset and Death |
| | disease or condition reaulting in death) | Hout | Acute Respiratory facture | | | | | | | | | | |
| | disease or condition resulting in death) a. Acute Respiratory facture DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions b. ADVANCED AIDS Relates Complex | | | | | | | | | | | | |
| NO | DIJE TO (OR AS A CONSEQUENCE OF) | | | | | | | | | | | | |
| FA | if any, leading to immediate cause. Enter UNDERLYING | 502 10 | | | | | | | | | | | |
| 임 | CAUSE (Disease or injury that initiated events | DUE TO | OR AS A CONSE | OUENCE (| OF): | | | | | | | | |
| CERTIFICATION | resulting in death) LAST | ı. | | | | | | | | | | | |
| | DADT II ON as death and as diller | | | | | | | | | | | 7 | |
| ¥. | PART II. Other algnificant condition | | | eauiting | in the u | nderiyin | g cause (| given in | Part I. | 24s. WAS AN PERFOR | | AV | RE AUTOPSY FINDINGS AILABLE PRIOR TO |
| ă | Mycobox ferion Avium | | | | | | | | | | | OMPLETION OF CAUSE F DEATH? | |
| Z | My Cobrac German | n_ Mill | Ч | | | | | | | | | 1 | YES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | | | 00 00 | 40F 0F 0 | EATH ON | | 1 | | | |
| PHYSICIAN: MEDICAL | EXAMINER? | HOSPITAL: | □ 53/0 -4-4/ | | OTHE | R: | | | neck only or | | | | |
| ₹ | 27. MANNER OF DEATH | 26s, DATE O | ER/Outpatient 3 | 28b. Til | _ | 26c. INJ | | sidence | 8 Othe | SCRIBE HOW I | NJURY OCC | CURED | |
| ā | 1 Natural 5 Pending | | Day, Year) | | IJURY M | WC | PK? | NO | 1 | | | | |
| ВУ | 2 Accident Investigation 3 Suicide 6 Could not be | | OF INJURY — At he | ome, farm, | atreet, fac | tory, offic | • | | | ATION (Street | | or Rural Rou | te Number, |
| | 4 Homicide determined | building | g, etc. (Specify) | | | | | | Clty | or Town, State) |) | | |
| E | 29a. CERTIFIER 1 CERTIFYING PHYSI | CIAN: To the best of | of my knowledge, de | ath occur | red at the | time, dete | and place | and du | to the car | use(a) and ma | nner sa stat | ed. | |
| COMPLETED | (Check only one) 2 MEDICAL EXAMINE | | The second second | | | | STATE WATER | | | or the second | | | nd manner as stated. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIES | | | | | | 29c. LIC | ENSE NU | MBER | | 29d. DAT | E SIGNED (M | onth, Day, Year) |
| BE | Kinis White | | | | | | | 7/6 | | | ► // | 1261 | 190 |
| 2 | 30. NAME AND ADDRESS OF PERSON WH | | HEE OF DEATH (ITE | M 273 (Ter | a Drint) | | | - | | - | | / / | , - |

UPPER MARIBORO

Living White MD

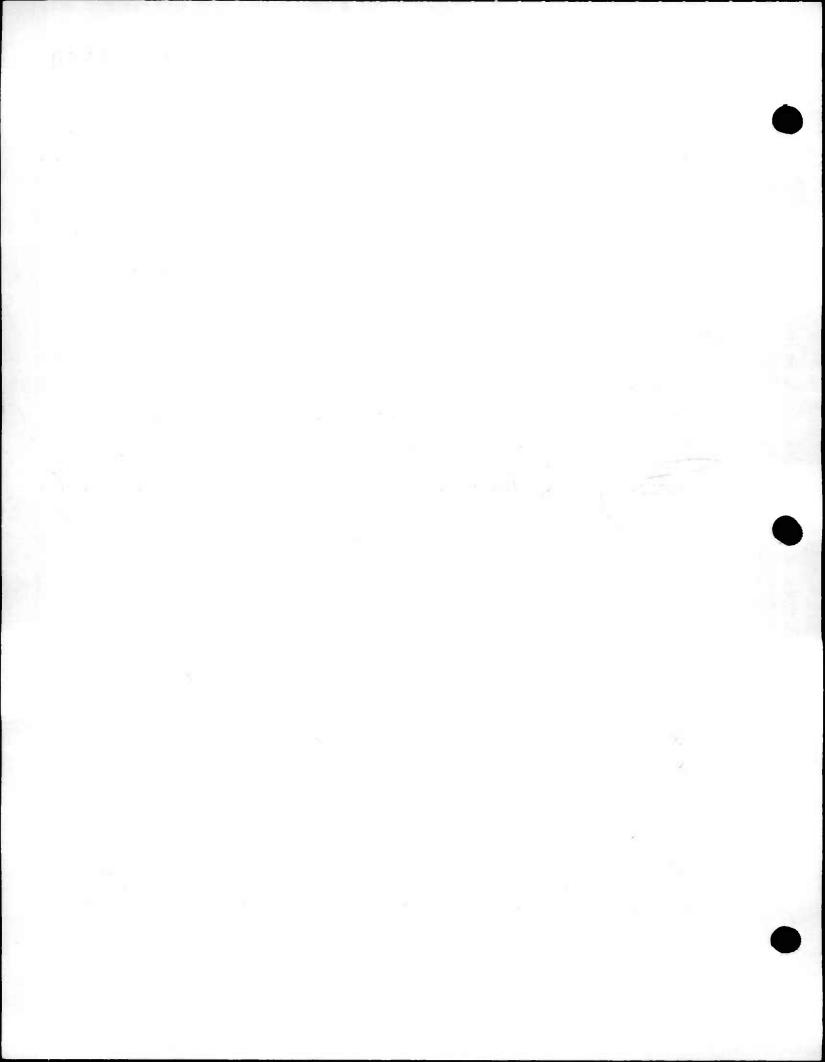
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

JINDA Whitby
31. DATE FILED (Month, Day, Year)

NOV 2 7 '90

9556 CRAIN Huy
32. REGISTRAR'S SIGNATURE

DHMH-16 Ray 1/89

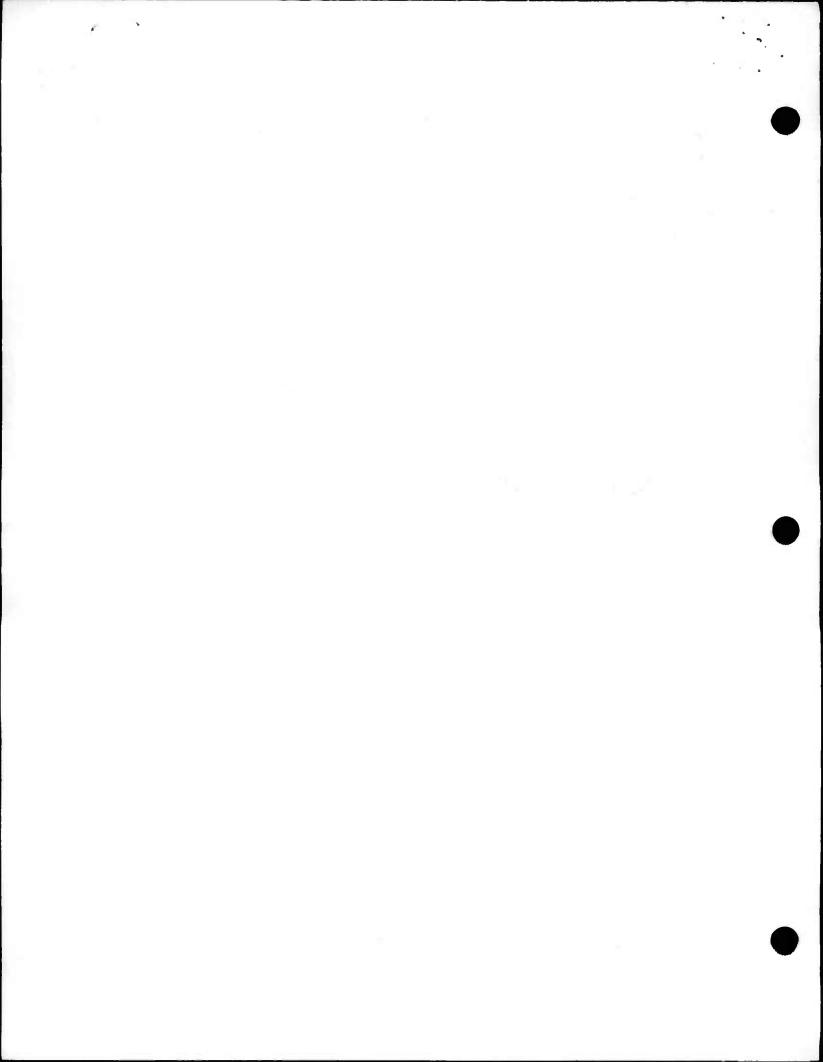


BALTIMORE, MARYLAND 21203-3146

| • | | FOR S 1 - STATE REGISTRAR | TATE OF MARYLA | | | HEALTH AND I | MENTAL HYGIEN REG. NO | E | 34461 | | | |
|--|---------------|--|--|--|---|--|---|----------------------------|--|--|--|--|
| | | 1. DECEDENT'S NAME (First, Middle, Lest) EVa | Bell | = 0 | Powel | 1 | 2. DATE OF DEATH DO NOVEMBER | 19 19 | 3. TIME OF DEATH | | | |
| (P |) | 214-10-8715 11 | □ M 2 🔀 F | 74 YRS. | IF UNDER 1 YEA MONTHS DAY | | 7. DATE OF BIRTH (Month, Day, Year) Sept. 16, | 1916 N | BIRTHPLACE (State or Foreign Country) Maryland | | | |
| 2 | СТОН | See. FACILITY NAME (II not institution, give street of Peninsula General H | | | | n or location of di isbury, MD | | 9c. COUNTY | icomico | | | |
| it. Pages | DIRE | 100. STATE 10b. COUNTY Maryland Wicomic | :0 | | y, town on Lo sonsbu | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO | | | |
| physician. burial-transit permit. Pages | FUNERAL | Waste Gate Road | | | | 101. ZIP CODE 21849 | | | USA | | | |
| | B | 11. MARITAL STATUS 1 Never Married 2 Merried 3 Widowed 4 Divorced | WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | XX NO | If yes, | DECENDENT OF HISPAR , specify Cuben, Mexics YES 2 XNO Specif | | e or No— 14. | RACE — American Indian, Black, White, atc. Specify: White | | | |
| by the hospital or attending be detached for use as the at once. | PLETED | 15, DECEDENT'S EDUCATION (Specify only highest grade composition of th | ON pleted) offege (1-4 or 5+) | 16a. DECEDENT'S (Give kind of itio. Do NOT u | work done during | ATION i most of working | 165. KIND OF BU | | 200 | | | |
| by the hospital be detached for at once. | E COMP | 17. FATHER'S NAME (First, Middle, Last) Clarence Bell | | | | | ME (First, Middle, Meiden 11a Campbe | Surname) | 8 | | | |
| be retained to | TO B | 190. INFORMANT'S NAME (Type/Print) Bonnie G. McMichael | | | | eet and Number or Rural 3017, Sali | Route Number, City or Tov .sbury, MD | vn, State, Zip Co 21801 | | | | |
| 2 2 | į | 20g, METHOD OF DISPOSITION 1 IX Burlel 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify) | from State S] | PLACE OF DISPO other place) oringhil | POSITION (Name of cometery, crematory or 1.11 Memory Gardens Hebron, MD | | | | | | | |
| ter death. Page 6 m. the funeral director, val. | | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Zeller Funeral Home Salisbury, MD 21801 | | | | | | | | | | |
| 24 frours at filled in by ion, or remother | | 22: PART/. Enter the diseases, or come hock, or heert fellure. List iMMEDIATE CAUSE (Final disease or condition resulting in death) | only one cause on e | the death. Do ach line. | Rock | mode of dying, euc | ch ee cerdiec or reep | iratory arreat | t, Approximete interval Between Onset and Death | | | |
| certificate be executed nding physician and con Hygiene prior to burial, or other traumatic en | CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury thet initiated evente reaulting in death) LAST | | | | | | | | | | |
| requires that the deepen signed by the of Heatth and Meshows any Injury | MEDICAL | PART II. Other significant conditions of | ontributing to death b | ut not resulting | in the underl | lying cause given in | | RMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 YES 2 NO | | | |
| The lar ite has ate Deg | SICIAN: | | OSPITAL: | patient 3 DOA | OTHER: | 8. PLACE OF DEATH (CI | 111= 11=11 | | | | | |
| this with | ву рну | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28s. DATE OF INJURY (Month, Day, Year) | 28b. Til | WE OF 28c | INJURY AT WORK? | 28d. DESCRIBE HOW | INJURY OCCUP | RED | | | |
| TTENDII TOR: A after de 28 is | MPLETED B | 3 Suicide a Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spe- | | street, factory, | offica | 28f. LOCATION (Street City or Town, State | | Rural Route Number, | | | |
| Z Z Z = | COMPLE | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: C | - | | | | | | cause(s) and menner ee stated. | | | |
| TO THE HOSPI TO THE FUNER be filed within IMPORTANT: | TO BE | 29b. SIGNATURE AND TITLE OF CENTIFIER | ALL THE CALL THE COLUMN TO THE CALL THE | CATAL STREET | a Orlan | 29c. LICENSE NU | 3 49 | 29d. DATE S | HIGNED (Month, Day, Year) | | | |

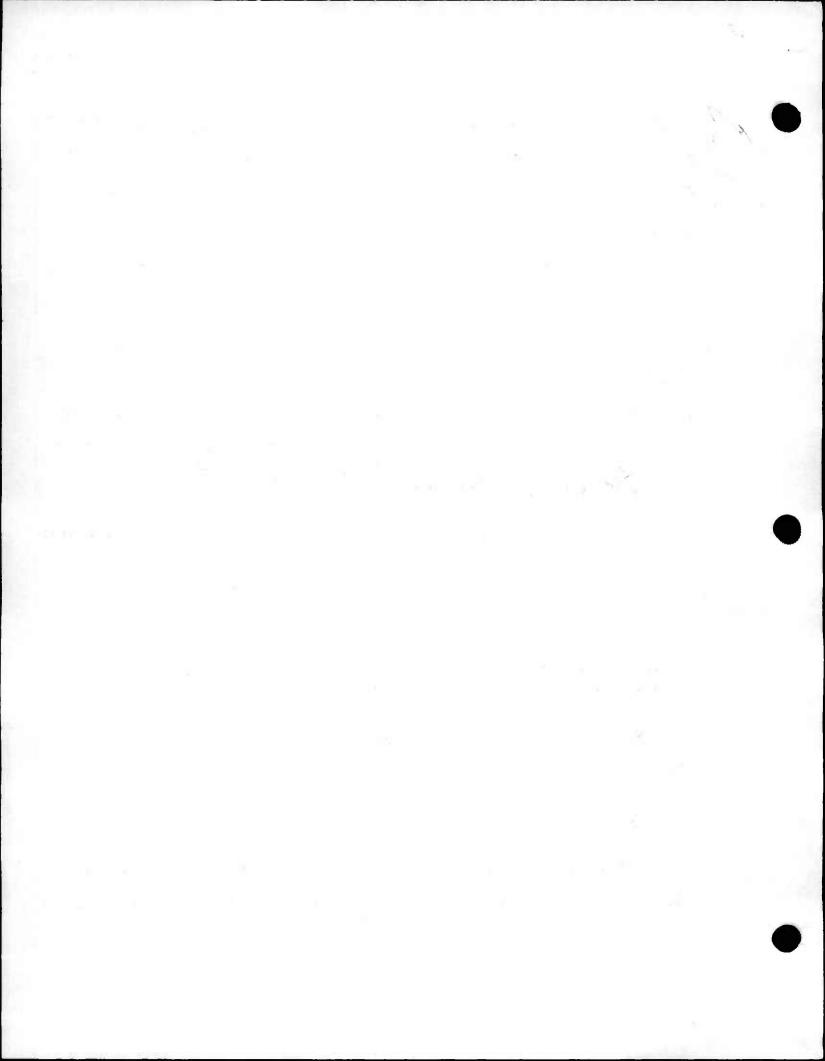
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) obins 50 AND CIVIC AVENUE, SALISBURY, MD ROUTE 31. DATE FILED (Month, Day, Year)

NOV 30 32. REGISTRADES SIGNATURE
Sulia Davidsor '90



| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by the hosp TO THE FUNERAL DIRECTIVE After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept. of Health and Mental Hyghers prior to build. certainston, or entroyal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|---|
|---|

| 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | | | |
|--|--|--|---|--|---|------------------------------|--|---|---|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) Jessie | Jessie L. L. Pier | | 2. DATE OF DI MONTH | | YEAR 90 | S. TIME OF DEATH | | | | |
| | 4: SOCIAL SECURITY NUMBER 237-05-6209 99. FACILITY NAME (If not institution, give a | 5. SEX 8. AGE (I | (Month, Day, Aug. 2: | DATE OF BIRTH 8. BIRTHPLACE (State or F Country) | | | | | | | |
| TOH | BREWIN NURSI | Ng Home | | | ede G | | | 1ATTO | | | |
| - DIRECTOR | | r Castle | | mingto | n | | | | IOG. INSIDE CITY LIMITS? I XYES 2 NO | | |
| FUNERAL | 100. STREET AND NUMBER 902 Anchorage S | treet | | | 01. ZIP CODE 19805 | | 2011 | TIZEN OF WH | IAT COUNTRY? | | |
| BY FUN | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES | 2 NO | If yes, a | CENDENT OF HISPAN specify Cuban, Maxica is 2 X NO Specify | n, Puarto Rican, | ecify Yea or No— etc.) | 14. RACE - Black, Specify: Whi | | | |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | 16a. DECEDENT'S L (Give kind of we life. Do NOT use Assemb | ork done during r retired.) | TION nost of working | Rebui | of Business/in | omobi | le | | |
| BE COM | 17. FATHER'S NAME (First, Middle, Last) William Danie | ls | | | 18. MOTNER'S NA Mary | ME (First, Middle, Unknov | Malden Surname) VN | | arcers | | |
| 2 | Sharon Pendleton | | 902 An | chorag | end Number or Rural I | Wilmir | ngton, I | elawa | | | |
| | 20a. METNOD QE DISPOSITION 1 | Si | other place) | k Ceme | tery Crem | atory | | | n, Stata Delaware | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LI | h E. H | icks | Bow Elkt | * Home fo & Stockto on, Maryl | n Stree | ets 1921 | | | | |
| NOIL | 23. PART I. Entar the diseases, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, abock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Finel disease or condition resulting in death) DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | |
| CERTIFICATION | cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST | cDUE TO (OR AS A | CONSEQUENCE OF |): | | | | | | | |
| PHYSICIAN: MEDICAL (| PART II. Other eignificent condition HYPERTEN PERIPHERA | ISION | | BASE. | ng cause given in | | WAS AN AUTOPS! PERFORMED? YES 2 NO | | WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1YES 2 NO | | |
| NAN. | 25. WAS CASE REFERRED TO MEDICAL | | | 26. | PLACE OF DEATN (Ch | eck only one) | | ν, , , | | | |
| IXSIC | EXAMINER? | HOSPITAL: 1 Inpatient 2 ER/Outp | 1117 | - | ome 6 - Residence | | | | | | |
| M 1 YES 2 NO | | | | | | | | CCURED | | | |
| | 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide datarmined | 28e. PLACE OF INJURY building, atc. (Spec | — At home, farm, s | treet, factory, of | lica | 281, LOCATION City or Tox | N (Street and Numb vn, State) | er or Rural Ro | ute Number, | | |
| 3 Success 4 Memicide 4 Memicide 5 Could not be datarmined 29e. CERTIFFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and menner as stated. | | | | | | | | and manner as stated. | | | |
| TO BE C | 296. SIGNATURE AND TITLE OF CERTIFIE | mi MD. | | | D 32 | 609. | 29d. D/ | II · S | Month, Day, Year) | | |
| F | 30. NAME AND ADDRESS OF PERSON W | MITHANI M | ATN (ITEM 27) (Type, | 33 G | RARD S | T. HAN | REDI | E GRE | Her . 21078 | | |
| | 31. DATE FILED (MONTO 2008) '90 | 32. REGISTRAR'S SIGN | | | | | | | | | |



BALTIMORE, MARYLAND 21203-3146

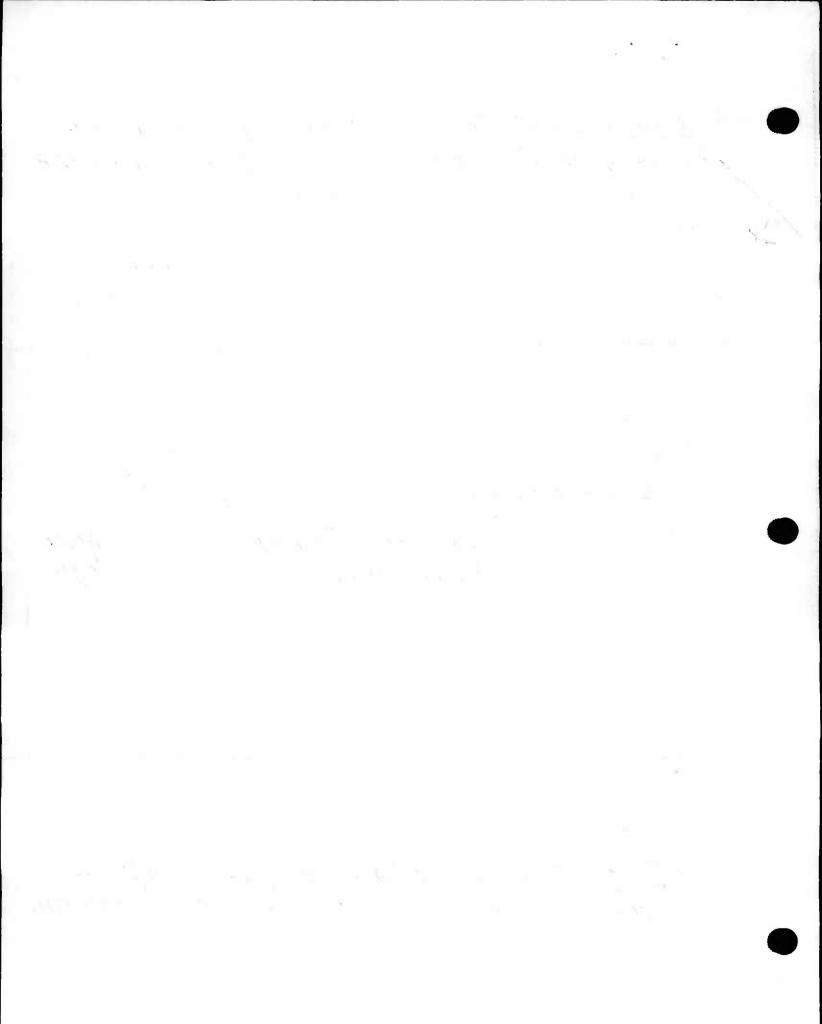
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 22 mous after death. Page 6 may be retained by the hospital or attending physician TO THE FINEFAL DIRECTOR, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-tra | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|
| IE HOSPITAL. OR ATTENDING PHYSICIAN: The law requires that IE FUNERAL DIRECTOR: After this certificate has been signed t | d within 72 hours after death with the State Dept. of Health at | DRTANT: If Item 28 is marked, or item 23 shows any |

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

| | 1. DECEDENT'S NAME (First, Middle, Last) Sidney I | Pet Pet | Rs. | Jr_5 | R· | 2. DATE OF DEA | JAY & | 3. TIME OF DEATH YEAR 9190 M |
|-----------------------|--|--|--|-------------------------|--|-----------------------------------|--|--|
| | 2 24-36-6558 1 BM 2 OF | GE (In yrs. less birtho | MONTHS | | IF UNDER 24 HRS. HOURS MIH. | 7. DATE OF BIRT (Month, Day, Y | 8-31 | 8. BIRTHPLACE (State or Foreign Country) |
| OR | 92. FACILITY NAME (If not institution, give street end number) Deaton Wedicale RESIDENCE OF DECEDENT | tr. | 9b. CIT | ALI | n LOCATION OF DEA | ATH) | | nty OF DEATH timore City |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY Maryland Cecil | | CITY, TOWN Elkto | | ON | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| ERAL | 10e. STREET AND NUMBER 118 Friendship Road | | | 101. | ZIP COOE 21921 | | | ZEN OF WHAT COUNTRY? |
| B | 11. MARITAL STATUS 1 Never Married 2 Married FORCES? 1 X 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | ER IN U.S. ARMED YES 2 NO OR DATES | 13 | If yes, spe | endent of Hispani city Cuban, Mexican 2 Specity: | , Puerto Rican, e | | 14. RACE American Indian, Black, White etc. Specify: White |
| COMPLETED | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1.2 College (1-4 or 5+) | Ilfe. Do No | nt's usual of of work done OT use retired. | e during mod .) | | | of Business/inc | lucts Mfg. |
| BE CON | 17. FATHER'S NAME (First, Middle, Lost) Sidney L. Pete | rs, Sr. | | | 18, MOTHER'S NAM | Norma | Maiden Surname) Connle | ÷У |
| 10 | 19a.INFORMANT'S NAME (Type/Print) Della M. Peters | 11 | 8 Fri | endsh | ip Road | E1k | ton, ME | 21921 |
| | 20a. METHOD OF DISPOSITION 1 1 | Church C | of the | Naza | arene Cen | netery | Elkton | city or Town, Stata , Maryland |
| | Donald S- Hicks | | | Bow E1k | p address of factions of the control | ckton S 21921 | treets | |
| | 23. PART I. Enter the diseasea, or complications that ca shock, or heart failure. List only one cause of IMMEDIATE CAUSE (Final disease or condition resulting in death) DUE TO (OR | | ton | sr tha mo | tallu | | reapiretory ar | reat, Approximata interval Batween Onset and Daath |
| ATION | Sequentially list conditions, If any, landing to immediata cause. Enter UNDERLYING | AS A CONSEQUENCE | CE OF): | 654 | | - 1 | | 6 ghs |
| ERTIFIC | CAUSE (Disease or injury that initiated events resulting in death) LAST | AS A CONSEQUENC | CE OF): | | | | | |
| MEDICAL CERTIFICATION | PART II. Other significant conditions contributing to des | ith but not result | ting in the t | undariyin | g cause given in i | P | MAS AN AUTOPSY PERFORMED? YES 2 NO | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| _ | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | ACE OF DEATH (Che | ock only one) | | |
| PHYSICIAN: | EXAMMER? 1 | URY 28b | OA 4 N | lursing Hom 28c. INJ | e 5 Residence | | HOW INJURY O | CUREO |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | JURY — Al home, fi | М | 1 🗆 | rES 2 NO | 281. LOCATION City or Town | (Street and Number 1, State) | or or Rural Route Number, |
| COMPLETED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the bast of my | | | | | | | |
| TO BE C | 206. SIGNATURE AND TITLE OF CRITIFIER AND THE STATE OF T | MI | 10 | N | 29c. LICENSE NUN | 6 22 | 29d. DA | TE SIGNEO (Month, Day Year) |
| F | 30, HAME AND ADDRESS OF PERSON WHO COMPLETE CAUSE OF U.O. C. C. C. C. C. C. C. C. C. C. C. C. C. | TA MO | (Type, Print) | /(5 | . Cha | iles | 5+ 1 | Balf Md 2/28. |
| | | astisen fo | ndell | | | | | OHMH-16 Rev 1/89 |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or regions, that the sentificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 is be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

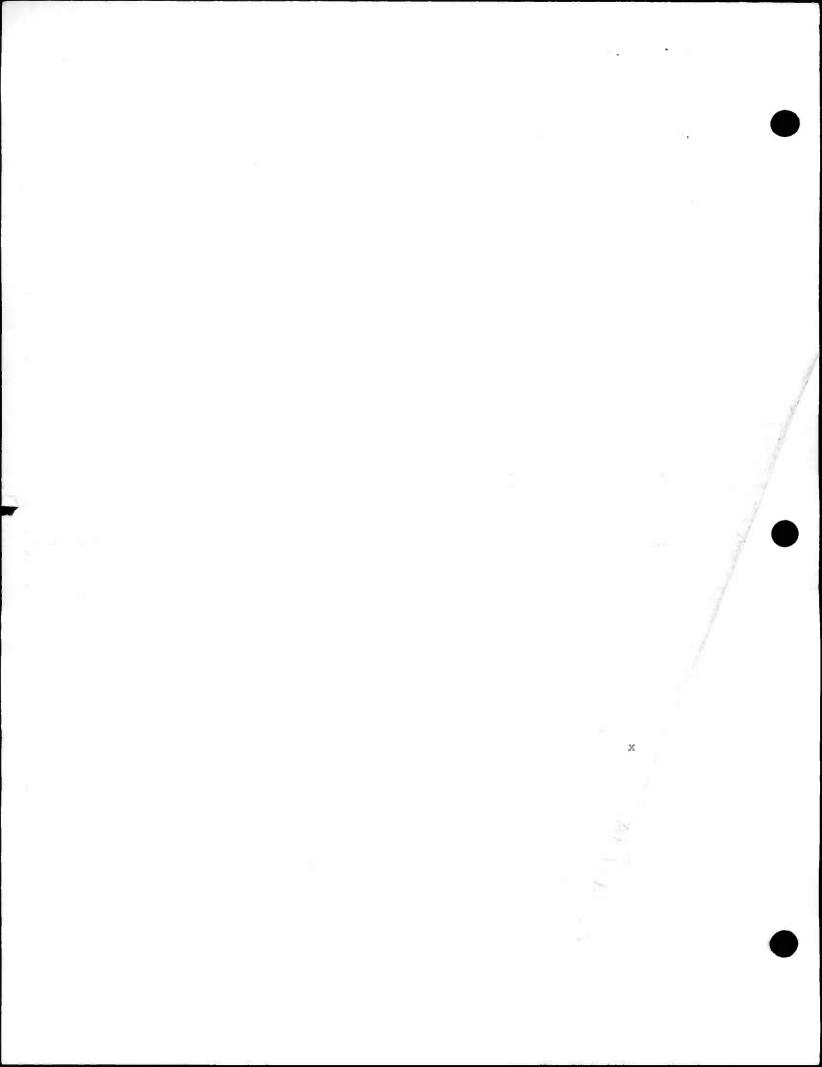
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| REGISTRAR | | CERTIFIC | ATE OF | DEATH | REG. NO | | |
|--|--|---|----------------------|--------------------------------|---|------------------------|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | - 0 |) [| | | 2. DATE OF DEATH MONTH DO | AY YEAR | 3. TIME OF DEATH |
| ELIZABETH | EP | EMNY | | | 12 | 3 90 | |
| 219-48-9870 | The same of the same of | | UNDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) APRIL 11. | Cou | THPLACE (State or Foreign intry) |
| De. FACILITY NAME (If not institution, give stre | A | | L CITY, TOWN O | R LOCATION OF DE | | 9c. COUNTY OF | |
| SOUTHORN MA | Rylman H | OSPITAL | C | 100001 | Υ | PRINC | - GEDRGE |
| MARYLAND 106. COUNTY PRINCE | E GEORGES | ACCO | OWH OR LOCAT KEEK | ION | | | 10d. INSIDE CITY LIMITS? 1 TYES 2 X NO |
| UNKNOWN | | | 10f. | 20607 | | 10g. CITIZEN OF | STATES |
| 11. MARITAL STATUS 1. Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER II FORCES? 1 YES IF YES, GIVE WAR OR D | 2 NO | If yes, spe | | IC ORIGIN? (Specify Yes, Puerto Rican, etc.) | Bi | CE — American Indian, ack, White, atc. ecity: BLACK |
| 15. DECEDENT'S EDUCA (Specify only highest grade of | ATION | 16a. DECEDENT'S US | UAL OCCUPATIO | N at al worlden | 18b. KIND OF BU | SINESS/INOUSTRY | , |
| Elementary/Secondary (0-12) | College (1-4 or 5+) NONE | (Give kind of work life. Do NOT use re COOK | tired.) | st or working | HOTEL | | |
| 7. FATHER'S NAME (First, Middle, Last) | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | |
| JAMES A. PENNY | | | | ELSIE F | OSEBUD PRO | OCTOR PE | NNY |
| 19e. INFORMANT'S NAME (Type/Print) | | 1 | • | | noute Number, City or You | | |
| ELSIE PROCTOR | | ROUTE | #1 BOX | 276 MARE | URY, MARY | LAND 20 | 0658 |
| 20e. METHOO OF DISPOSITION | val from State | o. PLACE OF DISPOSITI | | | | CATION — City or | Town, State |
| Donetion 5 🗆 Other (Specify) | I | INCOLN ME | | | | TLAND, N | IARYLAND |
| H. SIGNATURE OF FUNERAL SERVICE LICE LYDIA C. THORN | PON JOHNSON | bred | | ON'S FUN | ERAL HOME | , POMONK | ŒY, MARYLAND |
| Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | A CONSEQUENCE OF): | fail f hi | in | | | Onset and Death I would Syew Over 10 yr |
| PART II. Other significant conditions | contributing to death t | out not resulting in | tha underlying | j ceuse given in | Part I. 24a, WAS AF PERFO 1 YES | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF OEATH (Ch | eck only one) | | |
| EXAMINER? 1 YES 2 X NO | HOSPITAL: | | THER: | 65 tes | 6 Other (Specify) | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending | 28e. OATE OF INJURY (Month, Day, Year) | 28b. TIME C | OF 28c, INJ | | 28d. DESCRIBE HOW | INJURY OCCURED | |
| 2 Accident 3 Suicide 6 Could not be determined | 28e. PLACE OF INJURY building, etc. (Spe | Y — At home, farm, atre | et, factory, offic | • | 28f. LOCATION (Street City or Town, State | end Number or Rui) | ral Route Number, |
| one) 2 MEDICAL EXAMINER | CIAN: To the best of my know R: On the basic of examination | | | | time, data and place, a | | |
| 29b. SIGNATURE AND TITLE OF CENTIFIER | and my | alle | | 107 | 97.5 | D/8- | 390 |

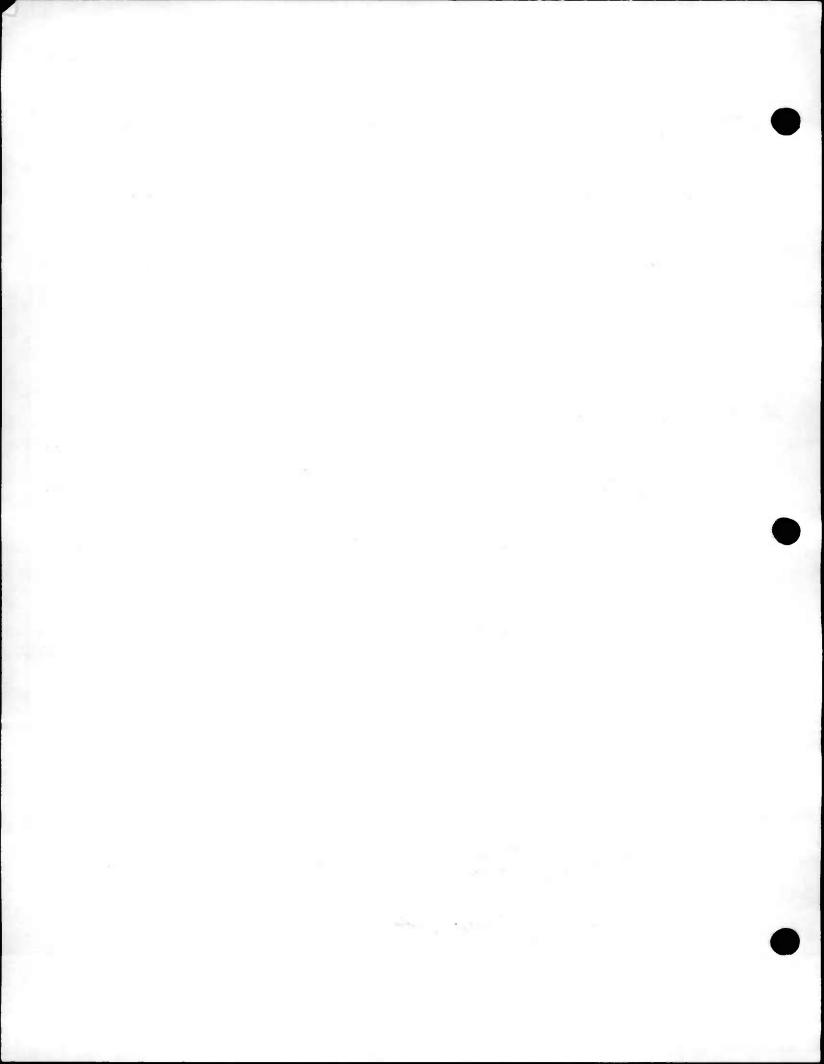


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a month of the death. Page 6 may be retained by the hospital or attending physician.

TO THE FINEFAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

| REGISTRAR | | CERTI | FICATE OF | DEATH | REG. NO | 0. | | |
|---|--|--|--|---|--|---|--|--|
| 1. DECEOENT'S NAME (First, Middle, Last) | | | OUTING | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
| RACHAEL T 4. SOCIAL SECURITY NUMBER | 5. SEX | 8. AGE (In yrs. last birthda) | OVENZ | Laurianian | 11 29 | | | 1:05 AM |
| 212-07-6172 | 1 M 2 TF | 84 VRS. | MONTHS DAVE | IF UNDER 24 HRS. HOURS MIN. | Jan. 24, | 1006 | Counti | |
| 9a. FACILITY NAME (If not institution, give s | | 04 1110 | | OR LOCATION OF O | <u> </u> | 9c. COUN | _ | yland |
| NORTH ARUNDEL HOS | · · | SOCIATION | | BURNIE | SAIN | | | COUNTY |
| 10e. STATE 10b. COUNTY | Y | 10c. C | CITY, TOWN OR LOCA | ATION | | | | 10d. INSIDE CITY |
| Maryland Anne | Arunde1 | G16 | en Burnie | of, ZIP CODE | | 10n CITIZ | ZEN OF 1 | 1 TYES 2 TO NO |
| 401 1st Ave. S.W. | | | | 21061 | | U.S | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 | IT EVER IN U.S. ARMED YES 2 X NO WAR OR DATES | If yes, a | | NIC ORIGIN? (Specify Yon, Puerto Ricen, etc.) y: | ea or No— | | E — American Indian, k, White, atc. <i>h</i> y: White |
| 15. DECEDENT'S EDU (Specify only highest grade | completed) | (Give kind o | T'S USUAL OCCUPAT of work done during m use retired.) | ION post of working | 16b. KIND OF 8 | USINESS/IND | USTRY | WILLOC |
| Elementary/Secondery (0-12) | College (1-4 or 5 | Homema | aker | | Own Ho | ome | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Maide | on Surname) | | |
| Robert Wright Tho | omas | | | | Collins | | | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | Route Number, City or To | | | |
| Nancy Fullerton | | | | | len Burni | | _ | |
| 1 ☐ Buriel 2XX remation 3 ☐ Rem | oval from State | other place) | oc mis · oca · · | emetery, crematory or | | OCATION — | | |
| 4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LIG | e a constant de la co | _ Metro C | rematory | , INC. | | onsvil | 11e, | Balto., |
| 21. SIGNATURE OF FUNERAL SERVICE LIC | Service . | 0 | | ey Funer | | | | |
| | | | 421 (| rain Hwy | | len Bu | rni | e. MD 210 |
| 23. PART I. Enter the diseesea, or | | | | | . S.E., G | | | Approximate |
| 23. PART I. Enter the disease, or ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | a. We | | o not enter the m | | S.E., G. | | | |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition | a. No one can be recorded to the can be recor | OCOC S | o not enter the m | ode of dying, suc | S.E., G. | | | Approximate interval Bet |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. DUE TO c. DUE TO d. DUE TO | OF AS A CONSEQUENCE | OP: | ode of dying, suc | S.E., G. th as cerdiac or ree | PIRETORY OFFI AN AUTOPSY ORMEO? | eat, | Approximate interval Bet |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO c. DUE TO d. DUE TO | OF AS A CONSEQUENCE | OP: | ode of dying, suc | S.E., G. th as cerdiac or ree to 5:5 Part I. 24e. WAS/ PERF | PIRETORY OFFI AN AUTOPSY ORMEO? | eat, | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | a. DUE TO c. DUE TO d. DUE TO | OF AS A CONSEQUENCE | OP): OP): OP): 28. In the underlying in the unde | ode of dying, suc | Part I. 24a. WAS/PERF | PIRETORY OFFI AN AUTOPSY ORMEO? | eat, | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | a. DUE TO b. DUE TO c. DUE TO d. DUE TO HOSPITAL: 1 Inpatient 2 | O O O O O O O O O O O O O O O O O O O | o not enter the m | ng ceuse given in | Part I. 24a. WAS/PERF | PIRETORY OFFI AN AUTOPSY ORMEO? | eat, | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending | a. DUE TO b. DUE TO c. DUE TO d. DUE TO HOSPITAL: 1 Inpatient 2 | OCAS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF AS A CONSEQUENCE OF THE CO | O not enter the m | ng ceuse given in | Part I. 24a. WAS/PERF | NA AUTOPSY ORMEO? 2 NO | 241 | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | B. DUE TO B. DUE TO C. DUE TO C. DUE TO DUE TO DUE TO DUE TO DUE TO DUE TO C. DATE TO MOSPITAL: 1 inpatient 2 28e. DATE D. 28e. PLACE | OCO S OO AS A CONSCOUENCE OO AS A CONSCOUENCE OO AS A CONSCOUENCE OO AS A CONSCOUENCE OF INJURY DER/Outpetient 3 DOO | OF): OF): OF): OF): OF): OTHER: 4 Nursing Ho TIME OF NURSING HO INJURY M 1 | ng ceuse given in | Part I. 24a. WAS. PERF 1 VES | AN AUTOPSY ORMEO? 2 NO | 24t | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | B. DUE TO B. DUE TO C. DUE TO C. DUE TO DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO DUE TO DUE TO C. DUE TO DUE TO C. DUE TO DUE TO DUE TO DUE TO C. DUE TO DU | DO CONTROL STATE OF INJURY — At home, fam. | o not enter the monotonic property of the underlying in the underl | ng ceuse given in PLACE OF GEATH (CI TORKY AT JYES 2 NO | Part I. 24a. WAS / PERF 1 VES 1 Other (Specify) 28d. DESCRIBE HOV 28f. LOCATION (Stree City or Fown, Stee to the cause(a) and residue to the cause(b) and residue to th | NA AUTOPSY ORMEO? 2 NO V INJURY OCC | 24t CURED or Rural | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | B. DUE TO B. DUE TO C. DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO DUE TO C. DUE TO C. DUE TO DUE TO C. DUE TO DUE TO DUE TO C. DUE TO | DO CONTROL OF INJURY — At home, fam. | o not enter the monotonic property of the underlying in the underl | ng ceuse given in PLACE OF OEATH (C) TORKY I YES 2 NO Note and place, and du death occurred at the | Part I. 24a. WAS / PERF 1 YES Deck only one) e Other (Specify) 28f. LOCATION (Stree-City or fown, Steel to the cause(a) and a setime, data and place, | AN AUTOPSY ORMEO? 2 NO V INJURY OCC et and Number te) namer as state and due to the | 24t CURED or Rural ted. | Approximatinterval Bet Onset and I Onset a |
| ahock, or haert fellure. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | B. DUE TO | DER/Outpetient 3 DOM FINJURY At home, fan, etc. (Specify) | O not enter the months of the corp. OF): | ng ceuse given in PLACE OF GEATH (CI TORKY AT JYES 2 NO | Part I. 24a. WAS / PERF 1 YES Deck only one) e Other (Specify) 28f. LOCATION (Stree-City or fown, Steel to the cause(a) and a setime, data and place, | AN AUTOPSY ORMEO? 2 NO V INJURY OCC et and Number te) namer as state and due to the | 24t CURED or Rural ted. ne cause E Signer | Approximatinterval Bet Onset and I Onset a |

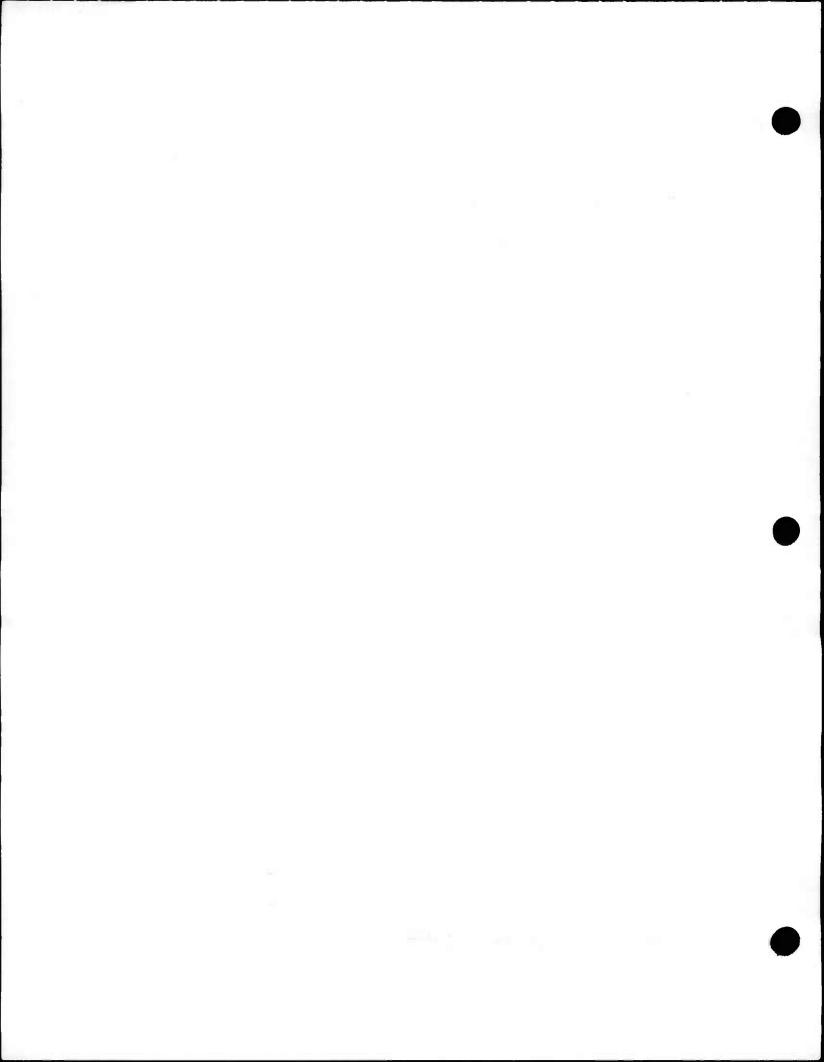


TO BE COMPLETED BY FUNERAL DIRECTOR

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | the State Dept. of Health and | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
|--|---|-------------------------------|--|
|--|---|-------------------------------|--|

| | FOR 1 - STATE REGISTRAR | STATE OF MARYLA | ND / DEPARTING | | | ENTAL HYGIENE REG. NO. | | 0 34466 |
|--------------------|--|---|--|------------------------------|---------------------------|---|-----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | TAME | AMES E. | PARKE | R | 2. DATE OF OEATH DAY | 3 40 | 3. TIME OF DEATH |
| 1 | 214-38-7525 | M2 DF | 93 YRS. MC | UNDER 1 YEAR | HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIRT Coun MA | HPLACE (State or Foreign stry) RYLAND |
| POR. | 9. FACILITY NAME (If not institution, give street ANNE ARUNDEL ME | DICAL CEN | | NNAPO | R LOCATION OF OEA | тн | ANNE | |
| DIRECTOR | 10e. STATE 10b. COUNTY | 4.0.000.000 | | OWN OR LOCAT | ION | | | 10d. INSIDE CITY LIMITS? 1 YES 2 NO |
| | MARYLAND ANNE | | LANNA | | ZIP COOE | | • | WHAT COUNTRY? |
| BY FUNERAL | 2003 FOREST DRI 11. MARITAL STATUS 1 ☐ Never Merried 2 ☐ Merried 3 ☒ Wildowed 4 ☐ Divorced | P. WAS OECEDENT EVER IN FORCES? 1 YES | 27 100 | 13. WAS DEC | city Cuben, Mexican, | C ORIGIN? (Specify Yes Puerto Rican, etc.) | or No — 14. RAC Ble | S . A . CE — American indien, ck, White, etc. |
| COMPLETED | 15. DECEDENT'S EDUCATI (Specify only highest grade con Elementary/Secondary (0-12) | | 18e. DECEDENT'S US (Give kind of won file. Do NOT use in | k done during mo stired.) | | 16b. KIND OF BUSI | INESS/INDUSTRY | A C K |
| Ŏ. | 17. FATHER'S NAME (First, Middle, Last) | | Enboi | K L I K | 18. MOTHER'S NAM | E (First, Middle, Maiden S | Surname) | |
| BE | JAMES H. PARKER | | | | | ETH PARK | | |
| 0 | 19e. INFORMANT'S NAME (Type/Print) | | | | | oute Number, City or Town | | WD 21/01 |
| | BRENDA ABNEY 200. METHOD OF DISPOSITION | 20b. | PLACE OF DISPOSIT | | | REET ANN. | APULIS ATION — City or 1 | |
| | 1 Surial 2 Cremetion 3 Remova 4 Donetion 5 Other (Specify) | | other place) ILL CRES | ST CEM | ETERY | ANN | APOLIS | , MD. |
| | 21, SIGNATURE OF EUNERAL SERVICE LICEN: | . Beese | | | | S MORTUR | | ANNAPOLIS, A. 21401 |
| | 23. PART I. Enter the disasses, or come shock, or haert fellure. Lie IMMEDIATE CAUSE (Finel disease or condition resulting in death) | st only one cause on ear | | enter the mo | de of dying, such | as cardiac or reapir | atory arrest, | Approximate Interval Between Onset and Deeth |
| CERTIFICATION | Sequentielly liet conditione, if eny, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | ` | CONSEQUENCE OF): | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other algnificant conditions of | ontributing to death bu | it not resulting in | the underlying | g cause given in F | Part I. 24a. WAS AN / PERFORI | MEO? | No. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | IQSPITAL: | | | ACE OF OEATH (Chec | ck only one) | | |
| | 1 YES 2 NO 1 27. MANNER OF DEATH 1 Natural 5 Pending | Inpatient 2 ER/Outpe 26e. OATE OF INJURY (Month, Day, Year) | | OF 26c. INJ | URY AT RES 2 NO | Other (Specify) 28d. DESCRIBE HOW IN | JURY OCCURED | |
| TED BY | 2 Accident investigation 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Specific | At home, ferm, atro | et, factory, offic | • | 28f. LOCATION (Street a City or Town, State) | nd Number or Rura | l Route Number, |
| COMPLETED | 29e. CERTIFIER 1 Check only one) 2 MEDICAL EXAMINER: | N: To the best of my knowle | _ | | | | | e(e) and manner ee stated. |
| TO BE (| 100 NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Tuno P | rint) | 96. LICENSE NUM 0 1165 | BER 3 | 29d. OATE SIGNI | ED (Month, Day, Year) 23-90 |
| | PETER F | VERKO | UW | | POREST | DR. A | пипри | his had |
| | NOV 3 0 1990 | ge. REGISTHAR'S SIGNA Julia Davidson | Adaptell | | | | | 21401 |

MD



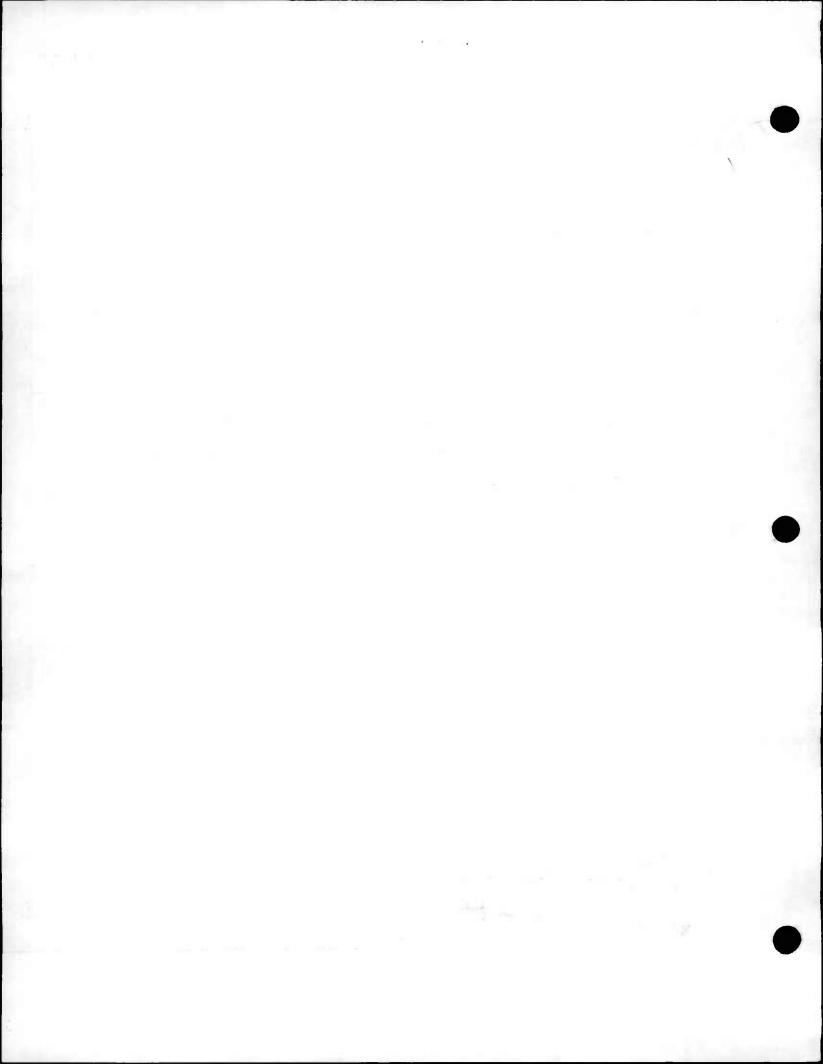
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | BALTIMORE, MARYLAND 21203-3146 | |
|---|---|--|
| OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within extractions after death. Page 6 may be retained by the hospital or attending physician | nours after death. Page 6 may be retained by the hospital or attending physician, | |
| DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the financial, cremation, or removal, | INRECTOR: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be mad Mental Hygiene prior to burial, cremation, or removal. | |
| | | |

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -CERTIFICATE OF DEATH REG NO 2. DATE OF DEATH MONTH 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 90 12:47 P M Paul Price 11 21 4. SOCIAL SECURITY NUMBER 5. SEX 8. BIRTHPLACE (State or Foreign 6. AGE (In vrs. last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH MONTHS DAYS HOURS MIN. 1 🔀 M 2 🗌 F VDC 214-48-2159 44 Maryland -4 - 469e. FACILITY NAME (If not institution, give street end number) 9b. CITY TOWN OR LOCATION OF DEATH DIRECTOR Anne Arundel General Hospital Annapolis, Anne Arundel 10e. STATE 10c, CITY, TOWN OR LOCATION 10d. INSIDE CITY LIMITS? Maryland Anne Arundel Severn 1 YES MYNO FUNERAL 10e. STREET AND NUMBER 10f, ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYPES 2 NO IF YES, GIVE WAR OR DATES 8117 Beverly 21144 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specity Yee or NoIf yes, specify Cuben, Mexican, Puerto Rican, etc.)
1 YES 2 NO Specify: 14. RACE — American Indian, Black, White, etc. 1 Never Married 2 Merried
3 Wildowed 4 Divorced Specify BY White COMPLETED 18a. DECEDENT'S USUAL OCCUPATION
(Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EDUCATION (Specify only highest grade completed) 16b. KIND OF BUSINESS/INDUSTRY Elamentary/Secondary (0-12) College (1-4 or 5+) 12 Auto Dealership YRS Sales Rep 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) notified at Paul William Price Marjorie P. Cunningham BE 19e. INFORMANT'S NAME (Type/Print) <u>Maria</u> E Price 8117 Beverly Ave. Severn, Md 21144 must be 20e. METHOD OF DISPOSITION
1 □ Burial 2 □ Cremation 3 □ Removal from State
4 □ Donation 5 □ Other (Specify) 20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or 20c. LOCATION — City or Town, State Baltimore Md Metro 21. SIGNATURE OF EXPERAL SERVICE LICENSEE examiner 22 NAME AND ADDRESS OF FACILITY Oath Hardesty Funeral Home aprile 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Md 21401 medical Approximate ahock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final Onset and Death the disease or condition Arteriosclerotic Cardiovascular Disease event, 1 resulting in death) DUE TO (OR AS A CONSEQUENCE OF): traumatic CERTIFICATION Sequentially list conditions. DUE TO JOR AS A CONSEQUENCE OF if any, laading to immedieta cause. Enter UNDERLYING cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events or other DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST Injury. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE PART II. Other algorificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24a. WAS AN AUTOPSY PERFORMED? PHYSICIAN: MEDICAL shows any 1 YES 2 | NO OF DEATH? 1 YES 2 | NO 23 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) Hem HOSPITAL: OTHER: 1 X YES 2 NO 1 ☐ Inpatient 2€☐ ER/Outpatient 3 ☐ DOA ng Home 5 🗆 Residence 6 🗆 Other (Specify) marked, or 27. MANNER OF DEATH 28s. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY 28c. INJURY AT WORK? 28d, DESCRIBE HOW INJURY OCCURED 5 Pending Investigation Natural м 1 YES 2 NO BY 2 Accident 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide .00 6 Could not be COMPLETED 4 Homicide 28 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(e) and manner as stated, TO THE HOSPITAL
TO THE FUNERAL I
BE filed within 72 h
IMPORTANT: If II (Check only one) 2 🔀 MEDICAL EXAMINER: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner se stated. E AND TITLE OF CERTABER 75b. 530 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) BE **OCME** 11/22/90 2

WHILLCOMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Ann M. Dixon, M.D. Renda 111 Penn St.

Baltimore, Md. 21201



| 1 | } | 1. DECEDENT'S NAME (First | Middle, Last) | · | | | | | | | | 2. DATE OF DEATH | DAY | YEAR | 3. TIME OF DEATH |
|--|------|---|--|--|------------|-----------------------------------|---------------------------|--------------------------|--|--|---------------------|--|---------------------------------------|------------|--|
|) } | | ISOBEL N | | + | | | | | | | | 11 20 | | 10 | 0831 A |
| V | П | 4. SOCIAL SECURITY NUME | ER | 5. SEX | 8. AGE (// | n yrs. last | | IF UNDER 1 | EAR MAYS | HOURS | HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | 8. BIRTI | HPLACE (State or Foreign try) |
| 1 | | 147-38-3278 | 3 | 1 🗆 M 2 🔭 F | 81 | | YRS. | | | | | 10-06-190 |)9 | New | York |
| | - 11 | 9a. FACILITY NAME (If not in | stitution, give | street and number) | | | | 9b. CITY, T | O MWC | R LOCATIO | N OF DEA | тн | 9c. COL | INTY OF E | DEATH |
| 1 8 | | NORTH ARI | INDEL | HOSPIT | ΑI | | | GLEN | -R1 | IRNTI | F MC | 21061 | ANN | ιΔ Δ | RUNDEL |
| <u>ු</u> වූ | F | RESIDENCE OF DEC | 10b. COUNT | | | | | TOWN OR | | | | | | | 10d. INSIDE CITY |
| DIRECTOR | | Maryland | | Arundel | | | 100. 011 | | | | Park | | | | LIMITS? |
| | 15- | 10e. STREET AND NUMBER | Aine | Atunder | _ | | | 26:1 | reri | ZIP CODE | Palk | | T 100 CI | TIZEN OF | 1 YES 2X NO |
| A | | 503 Heavit | coo Ta | no con | 70 YN 7 | 222 | -1- | | 100 | | 1146 | | | | |
| FUNERAL | H | 11. MARITAL STATUS | .eea | 12. WAS DECEDE | verna | - | | 12 W | S DEC | | | C ORIGIN? (Specify Y | | U.S. | A . E — American Indian, |
| | - 11 | 1 Never Married 2 | Merried | FORCES? | YES | 2 ZN | 0 | 10.3 | es, sp | city Cuben | , Mexicen, | Puerto Ricen, etc.) | or No | Bled | k, White, etc. |
| B | | 3 🕅 Widowed 4 🗌 Dive | orced | IF YES, GIVE | MAR OR DA | ITES | | 11 | YES | 2X NO | Specify: | | | Cal | ucasian |
| | - | 15, DEC | EDENT'S ED | ICATION | | 16a. DEC | EDENT'S | JSUAL OCC | UPATIC | IN . | | 16b. KIND OF B | JSINESS/IN | DUSTRY | - |
| 1 | | (Specify online) Elementary/Secondary (1) | y highest grad | College (1-4 or 5 | +) | Ho. | e kind of w Do NOT use | ork done du retired.) | ing mo | st of working | 7 | | | | |
| . 로 | | 12+ | | | 1 | | Home | makei | - | | | | Hcm | e | |
| once. COMPL | | 17. FATHER'S NAME (First, M | liddle, Last) | | | | | | | 18. MOTH | ER'S NAM | E (First, Middle, Maide | | | |
| ш | | John Nea | ary | | | | | | | S | arah | Fitzpa | atric | k | |
| TO B | | 19e. INFORMANT'S NAME (| Type/Print) | | | 19b | MAILING | ADDRESS (| Street e | nd Number | or Rural Ro | oute Number, City or To | wn, State, Z | (Ip Code) | 07092 |
| | | Mr. John N. | Post | | | | 10 | 17 | 15 | 57 Cc | les | Avenue Mo | ounta | insi | de, NJ |
| 2 | | 20e METHOD OF DISPOSIT | ION | | 20b | PLACE (| F DISPOS | ITION (Nam | | | | | OCATION - | | |
| \$ E | | 4 Donation Other | | noval from State | _ | Fair | view | Ceme | ete | СУ | | We | estfi | eld. | N.J. |
| 2 | | 21. SHOWATURE OF FUNERA | L SERVICE Y | CENSEE | | | | 22 N | ME A | ID ADDRES | S OF EAC | ns Funera | | | |
| examiner must | | 4 min | 5 | XXXI | Ma | 208 | | | | | | | | | MD 21146 |
| | 4 | JOY THE | - | 17005 | 141 | ILU | * 0 | | | | | | | | |
| medical | н | 21 PART Enter the d shock, or h | eert feilure. | List only one ca | se on e | sch line. | nn. Do n | or enter t | ie mo | as or ayı | ng, sucn | es cerdiec or ree | piretory e | rreat, | Approximete interval Between |
| 9 | 1 | IMMEDIATE CAUSE (Fi | nai | 1/ | | 1 | | 0 | | 11 | | | | | Onset end De |
| - | | resulting in desth) | \rightarrow | 1000 | mi | al | my | 171 | YZ | Al . | | | | | New min |
| event, | | | | DUE TO | OR AS A | CONSEC | NI | 1 | 0 | 0. | | CI- | | | Since 11 |
| N N | | Sequentially list condi- | ions, | b. SCHUL | OR AS A | CONSE | | tus | 0/ | ryra | KM_ | Herm | | | |
| ATION | | if sny, leading to imme | diets | 5/00 | (Un As A | CONSE | y M | 0+ | 1/ | males. | Fiel | asto | | | 11. 1 |
| TIFIC | | CAUSE (Disease or Inje | | c. DUE TO | (OH AS A | CONSTO | UENCE OF |): | | ~~ ~v/ | 7 4 | wary | | | unknou |
| 513 | | that initiated events resulting in death) LAS | ET . | | 7,0 54,1 | /- | | • | | | | 0 | | | |
| 키뉴 | | | | d. | | | | | | | | | | | |
| CERT | | | | | | | | | erivin | cause o | iven in F | nene | N AUTOPS | Y 24 | b. WERE AUTOPSY FINDIN |
| Injury, or AL CER | | PART II. Other signification | | | | | _ | | | | and a | | | | |
| any inju | | | | ns contributing to | | | _ | | | | 98 | 3 1 TES | DRMED? | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| amy inju | | | | | | | _ | | | | 98 | < | DRMED? | | AVAILABLE PRIOR TO |
| MEDICAL | | | | | | | _ | | | | 98 | < | DRMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | | 25. WAS CASE REFERRED | ance Ango | no il | | | _ | | 7 | in 1 | 98. | < | DRMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| MEDICAL | | | ance Ango | | 1 | Vry | B. Oct | OTHER | 28. PI | ACE OF D | EATH (Che | 1 TYES | DRMED? | | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| or Item 23 shows any inju IYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? | ance Ango | HOSPITAL: 1 Unpatient 2 28a. DATE O | ER/Outp | Vry | B) Oct | OTHER: | 28. Pl | ACE OF DI | EATH (Che | 1 UYES | DRMED? | CCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| or Item 23 shows any inju- IYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 MANUER OF DEATH 1 Netural 5 | angel angel on MEDICAL | HOSPITAL: 1 Unpatient 2 28a. DATE O | ER/Outp | Vry | B. Oct | OTHER: | 28. Pl 19 Horn 8c. INJ WC | ACE OF D | EATH (Che | 1 UYES | DRMED? | CCURED | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| marked, or item 23 shows any inju BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 MANUAL PROPERTY OF DEATH 1 Netural 5 2 Accident | Angs To MEDICAL Pending Investigation | HOSFITAL: 1 Vinpatient 2 28a. DATE 0 (Month, | ER/Outp | entient 3 | DOA 28b. TIM | OTHER: 4 Nursi | 28. Pl 19 Horn 8c. INJ WC | LACE OF DI | EATH (Che | ck only one) B Other (Specify) 28d. DESCRIBE HOV | PAMED? 2 NO / INJURY O | | AMILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO |
| marked, or item 23 shows any inju BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 MANUAL PROPERTY OF DEATH 1 Netural 5 2 Accident | angel angel on MEDICAL | HOSFITAL: 1 Vinpatient 2 28a. DATE 0 (Month, | ER/Outp | entient 3 | DOA 28b. TIM | OTHER: 4 Nursi | 28. Pl 19 Horn 8c. INJ WC | ACE OF DI | EATH (Che | 1 YES ck only one) 6 Other (Specify) 28d. DESCRIBE HOW | PAMED? 2 NO / INJURY O | | AMILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO |
| marked, or Item 23 shows any Inju BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 Homicide 29a. CERTIFIER 1 CEED | Pending investigation Could not be determined | HOSPITAL: 1 Vinpatient 2 28a. DATE 0 (Month, | ER/Outp | milent 3 | DOA 28b. TIMI | OTHER: | 28. Pl ng Horn 8c. INJ WC 1 y, office | ACE OF DI | EATH (Cho | ck only one) B Other (Specify) 28d. DESCRIBE HOV 28f. LOCATION (Street, City or Town, Ste | DRMED? 2 NO VINJURY O | er or Rura | AMILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO |
| If Item 28 is marked, or Item 23 shows any inju MPLETED BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only) | Pending Investigation Could not be determined | HOSPITAL: 1 Vinpatient 2 28a. DATE 0 (Month, Duliding | ER/Outp | entient 3 — At horally ledge, de | DOA 28b. TIMINJ | OTHER: 4 Nursi | 28. PI 19 Horn 8c. IN. WC 1 y, office | ACE OF DI No. 5 Re URY AT HEK? YES 2 | EATH (Cho | ck only one) B Other (Specify) 28d. DESCRIBE HOV 28f. LOCATION (Street City or Town, Steet to the cause(e) and in | DRMED? 2 NO VINJURY O | er or Rura | AMALABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO |
| If item 28 is marked, or Item 23 shows any inju MPLETED BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANYER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 Homicide 29a. CERTIFIER (Check only one) 2 MEE | Pending Investigation Could not be determined TIFYING PHY- | HOSPITAL: 1 Inpetient 2 28a. DATE O (Month.) 28e. PLACE building | ER/Outp | entient 3 — At horally ledge, de | DOA 28b. TIMINJ | OTHER: 4 Nursi | 28. PI 19 Horn 8c. IN. WC 1 y, office | ACE OF DI L | EATH (Che sidence (| 28d. DE\$CRIBE HOV 28d. DE\$CRIBE HOV 28d. DCATION (Street, St | DRMED? 2 NO VINJURY O wt and Numb te) | tated. | AMILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO Route Number, |
| Is marked, or Item 23 shows any Inju D BY PHYSICIAN: MEDICAL | | 25. WAS CASE REFERRED EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 2 Accident 3 Suicide 6 4 Homicide 29a. CERTIFIER (Check only) | Pending Investigation Could not be determined TIFYING PHY- | HOSPITAL: 1 Inpetient 2 28a. DATE O (Month.) 28e. PLACE building | ER/Outp | entient 3 — At horally ledge, de | DOA 28b. TIMINJ | OTHER: 4 Nursi | 28. PI 19 Horn 8c. IN. WC 1 y, office | ACE OF DI LE 5 Re LURY AT PRIC7 YES 2 Lend place, Lenth occur 29c. LICE | EATH (Cho | 28f. LOCATION (Street, or Yown, Steet) to the cause(e) end in time, date and place, | DRMED? 2 NO VINJURY O wt and Numb te) | tated. | AMILABLE PRIOR TO COMPLETION OF CAUSI OF DEATH? 1 YES 2 NO Route Number, |

and i made of the state of the

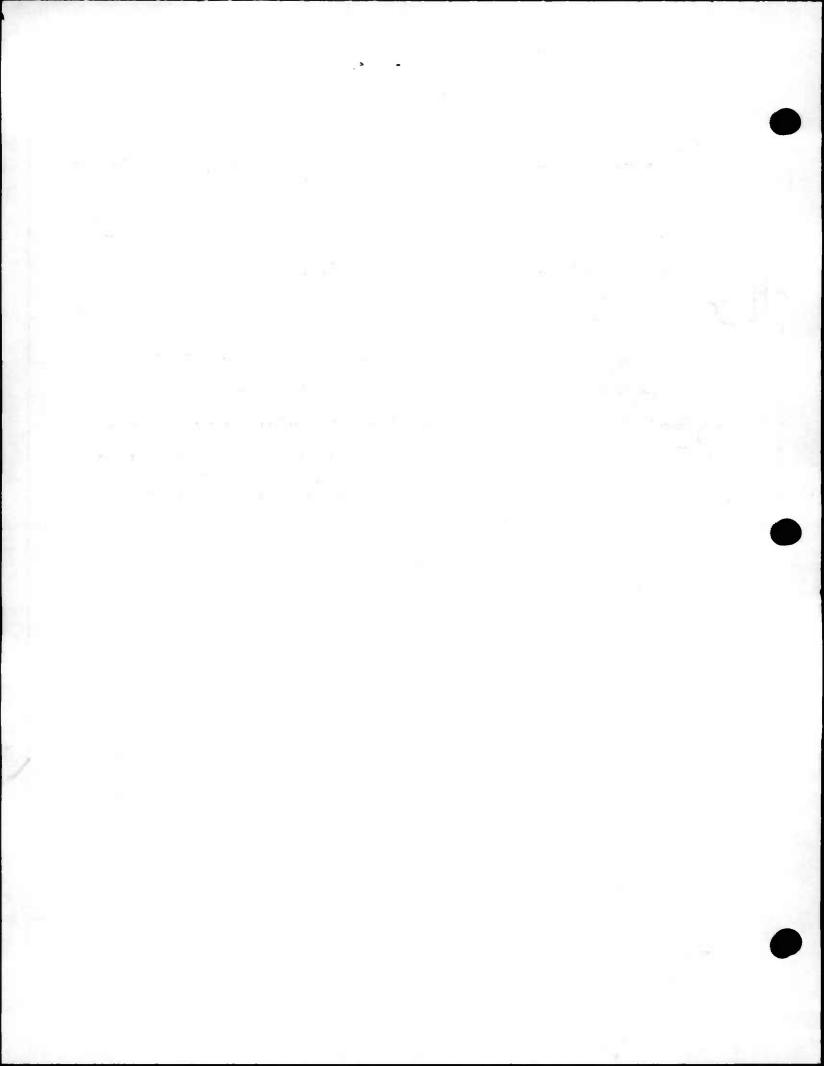
| | | 1 - STATE REGISTRAR | STATE OF MARYL | | RIMENT OF | | MENTAL HYGIEN REG. NO | | |
|--|-------------------|--|---|---------------------------------|--------------------------------|----------------------------------|---|----------------|---|
| | | 1. DECEDENT'S NAME (First, Middle, Last) | L. PANK | rex | | | 2. DATE OF DEATH DO D | AY 9 9 | 3. TIME OF DEATH 8 9:60 A M |
| O | 1 | 4. SOCIAL SECURITY NUMBER | · M | In yrs lest birthday) | IF UNDER 1 YEAR MONTHS DAYS | | 7. DATE OF BIRTH (Month, Day, Year) | 8. | BIRTHPLACE (State or Foreign Country) |
| (31) | y. | 243-12-0010 9a. FACILITY NAME (If not institution, give str | | 0 YRS. | 9b. CITY, TOWI | N OR LOCATION OF DE | 10:12:2 | 9c. COUNTY | OSA-NC. |
| 23 | 16 | 348 Walker St. | | | Aberd | een | | Harf | ord |
| Pages 1 | ECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CIT | TY, TOWN OR LOC | CATION | | | 10d. INSIDE CITY LIMITS? |
| ii. Pa | DIR | | L FORD | A | BERL | | | | 1 VES 2 NO |
| slt permit. | RAI | 100. STREET AND NUMBER | CER ST | _ | | 101. ZIP CODE | n I | 10g. CITIZEN | OF WHAT COUNTRY? |
| 03-3146 attending physician. se as the burial-transit | Y FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married | 12. WAS DECEDENT/EVER IN FORCES? 1 (\(\bar{\text{V}}\) YES IF YES, GIVE WAR OR DO | U.S. ARMED 2 NO | I1 yes, | | IIC ORIGIN? (Specify Yen, Puerto Ricen, etc.) | | RACE — American Indian, Black, White, etc. Specify: Black |
| 3-31 tending as the | D BY | 3 Widowed 4 Divorced 15. DECEDENT'S EOUC | WW II | 16e. DECEDENT'S | USUAL OCCUPA | TION | 16b. KIND OF BU | SINESS/INDUS | |
| 212 ital or 1 for u | COMPLETED | (Specify only highest grade of Elementery/Secondery (0-12) | | (Give kind of life. Do NOT u | work done during | most of working | milit | | 101 |
| AND 2: the hospital detached fo | WO. | 17. FATHER'S NAME (First, Middle, Lest) | | | COOK | 16. MOTHER'S NA | ME (First, Middle, Maiden | | |
| ed by | 6 | Willie Pankey 190. INFORMANT'S NAME (Type/Print) | | 1 404 14411 1111 | 0.4000000 (0 | | Buchanan Route Number, City or Tov | | |
| WARYLAND e retained by the hosp 5 Should be detached | TO BE | Veleria Pankey | | | , | | en MD 21 | | oe) |
| | on venill | 20s. METHOD OF DISPOSITION 10 Burlel 2 Cremation 3 Remo | val from State | PLACE OF DISPO | SITION (Name of | cometery, cremetory or Nat'l Cer | 20c. LC | | y or Town, State • VA |
| 0 = 1 | CAGIIIIICA | 21. SIGNATURE OF FUNERAL SERVICE LICE | Bend | | Arno | | ard Funera Havre de | | |
| Zersours af filled in by tion, or remo | event, ule meuted | 23. PART I. Enter the diseases, or cashock, or heart failure. LIMMEDIATE CAUSE (Finel disease Dr condition resulting in death) | Lat only one cause on e | ONAC | | | th as cardiac or resp | | Intarval Between |
| CO. BOX 13: th certificate be execu ending physician and I Hygiene prior to bur | ERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | HYPE | A CONSEQUENCE O | NSIL | AC | | | |
| THAT THE CHAPTER OF T | MEDICAL | PART II. Other significant conditions | | out not reaulting | - | ring ceuse given in | Part I. 24e. WAS AI PERFO | RMED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 \(\square\) NO |
| TAL The lanter that the that the that the that the that the that the that the thet the thet the thet the thet the the | SICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | PLACE OF DEATH (C) | neck only one) | | |
| SICIAN: The | خ∣خ | 1 XYES 2 NO | 1 Inpatient 2 ER/Out | patient 3 DOA | 4 - Nursing H | INJURY AT | 8 Other (Specify) 28d. DESCRIBE HOW | IN ILIBA OCCIN | RED |
| PHYS r this of | BY PI | 1 Netural 5 Pending | (Month, Day, Year) | 16 | JURY | WORK? YES 2 NO | ~ € | | |
| DIVISION OF VITAL RECCO OR ATTENDING PHYSICIAN: The law requires DIRECTOR: After this certificate has been sign hours after death with the State Dept. of Heal | ED | 2 Accident investigation 3 Suicide 6 Could not be determined | 26a. PLACE OF INJURY building, atc. (Spe | / — At home, farm, | | ffice | 281. LOCATION (Street City or Town, State | 9) | Rural Route Number, |
| DIVI TO THE HOSPITAL OR AI TO THE FUNERAL DIREC be filed within 72 hours a | COMPLETED | one) | CIAN: To the best of my know | | | | | | cause(s) and manner ea stated. |
| H H H | BEC | 296 SIGNATURE AND TITLE OF CERTIFIER | Λ | | | 29c. LICENSE NU | | | SIGNED (Month, Day, Year) |
| 5 5 3 | 10 B | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALLOS CO | CATH STEEL OF CT | Christi | D21 | 809 | ► N | 00 25 1990 |
| | | GPRABHU | 1810 38 | LAIL | | +102 5 | PAUSO | 2 74 | 21047. |
| | | DEC 05 900 | 12. REGISTHAR'S SIGN | Mandell | | | | | |

. . .

| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2ours after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNEPAL DIRECTOR: After this centificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages | State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: I item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
|--|--|--|---|
| TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certifica | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending ph | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIE REG. N | NE | 0 34470 | | |
|--|--|--|--|-------------------------------------|--------------------------------|--|---|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH | DAY Y | 3. TIME OF DEATH | | |
| | | uart | P. | Powers | | 11-27-9(| | 1:05PM W | | |
| | 4. SOCIAL SECURITY NUMBER 218-10-1203 | 1)X M 2 🗆 F | (In yrs. lest birthday) _ | IF UNDER 1 YEAR MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) 9/8/05 | | BIRTHPLACE (State or Foreign Country) Virginia | | |
| _ | 9a. FACILITY NAME (If not institution, give st | Contract of the Contract of th | | | R LOCATION OF DEA | | 9c. COUNTY | | | |
| 6 | 1258 Washington Blvd. Baltimore City N/A | | | | | | | | | |
| FUNERAL DIRECTOR | 10a. STATE 10b. COUNTY Md. N/A | 7 | | town or Locat | | | 10d. INSIDE CITY LIMITS? 1 VE YES 2 \(\text{NO}\) | | | |
| اد | 10e. STREET AND NUMBER | | | | ZIP CODE | | 10g. CITIZEN | N OF WHAT COUNTRY? | | |
| F. | 1258 Washington | Blvd. | | 2 | 1223 | | | USA | | |
| BY FUN | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YES IF YES, GIVE WAR OR I | 2 X NO | 13. WAS DEC | | | Yea or No- 14 | I. RACE — American Indien, Black, White, etc. Specity: White | | |
| | 15. DECEDENT'S EDU | | 16a. DECEDENT'S | | | 16b. KIND OF I | BUSINESS/INDUS | TRY | | |
| COMPLETED | (Specify only highest grade Elementary/Secondary (0-12) | College (1-4 or 5+) | (Give kind of w life. Do NOT use | rork done during mo- e retired.) | st of working | | | | | |
| 릴 | 12 | | Sheet M | etal Wor | ker | Koppe | rs Comp | any | | |
| Š | 17. FATHER'S NAME (First, Middle, Last) | | | | 18. MOTHER'S NAM | ME (First, Middle, Meid | len Surname) | | | |
| BEC | Robert W. Powe | rs | | | Carrie | Cox | | | | |
| TO B | 19e. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street e | nd Number or Rural R | loute Number, City or | Town, State, Zip Co | ode) | | |
| F | Genevieve N. Powe | rs | 1258 | Washingt | on Blvd. | , Balto. | , Md. | 21223 | | |
| | 20a METHOD OF DISPOSITION 1 A Burlel 2 Cremation 3 Rem 4 Donation 5 Other (Specify) | ovel from State | b. PLACE OF DISPOS other place) Lorraine | | | | altimor | , | | |
| | 21. SIGNATURE OF PURENAL SERVICE LIK | L. Kouf | men | Gary | I. Kaufm Main St. | an Funer , Elkrid | al Home ge, Md. | s 21227 | | |
| NO | IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, | b | | F): | cular dis | sease | | Interval Between | | |
| CERTIFICATION | if any, leading to immediata cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | cDUE TO (OR AS | A CONSEQUENCE OF | า: | | | | | | |
| CAL | PART II. Other aignificent condition | ne contributing to deeth | but not resulting i | in the underlyin | g ceuse given in | PERI | AN AUTOPSY FORMED? | 24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? | | |
| M | | | | | | _ | TOTAL CAR | 1 TYES THE NO | | |
| PHYSICIAN: MEDI | | | | | | | PECTION | 1 | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | LACE OF DEATH (Ch | | | | | |
| XS | XX YES 2 □ NO | 1 Inpetient 2 ER/Ou | | | ne 5 Residence | 1., | | | | |
| ву рн | 27. MANNER OF DEATH 1 XXXxtural 5 Pending 2 Accident Investigation | 26e. DATE OF INJURY (Month, Day, Year) | INI | M 1 🗆 | IURY AT ORK? YES 2 NO | 28d. DESCRIBE HO | | | | |
| | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE OF INJUI building, etc. (Sp | RY — At home, farm, : ec/fy) | street, factory, offic | • | 281. LOCATION (Str City or Town, St | | Rural Route Number, | | |
| Suricios 6 Could not be determined building, etc. (Specify) 29e. CERTIFIER (Check only one) 27 MEDICAL EXAMINER: On the basis of examination analysis investigation, in my opinion, death occurred at the time, date and place, and due to the cause(e) and ma | | | | | | | | | | |
| | 296. SIGNATURE AND TITLE OF CHILIFLE | HO YOU | 1 | V | 29c. LICENSE NUM | MBER | 29d. DATE S | SIGNED (Month, Day, Year) | | |
| TO BE | 30. NAME AND ADDRESS OF PERSON WI | HO COMPLETED CAUSE OF E | PEATA (ITEM #7) (Topic | Print) | OCME | | ▶ 11- | -28-90 | | |
| | MARIO F. GOLLE, | | | | nn Street | t,Baltimo | re,MD 2 | 21201 | | |
| | 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIG | NATURE | M | | | | | | |





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 yours after death. Page 6 may be retained by the hospital or attending physician.

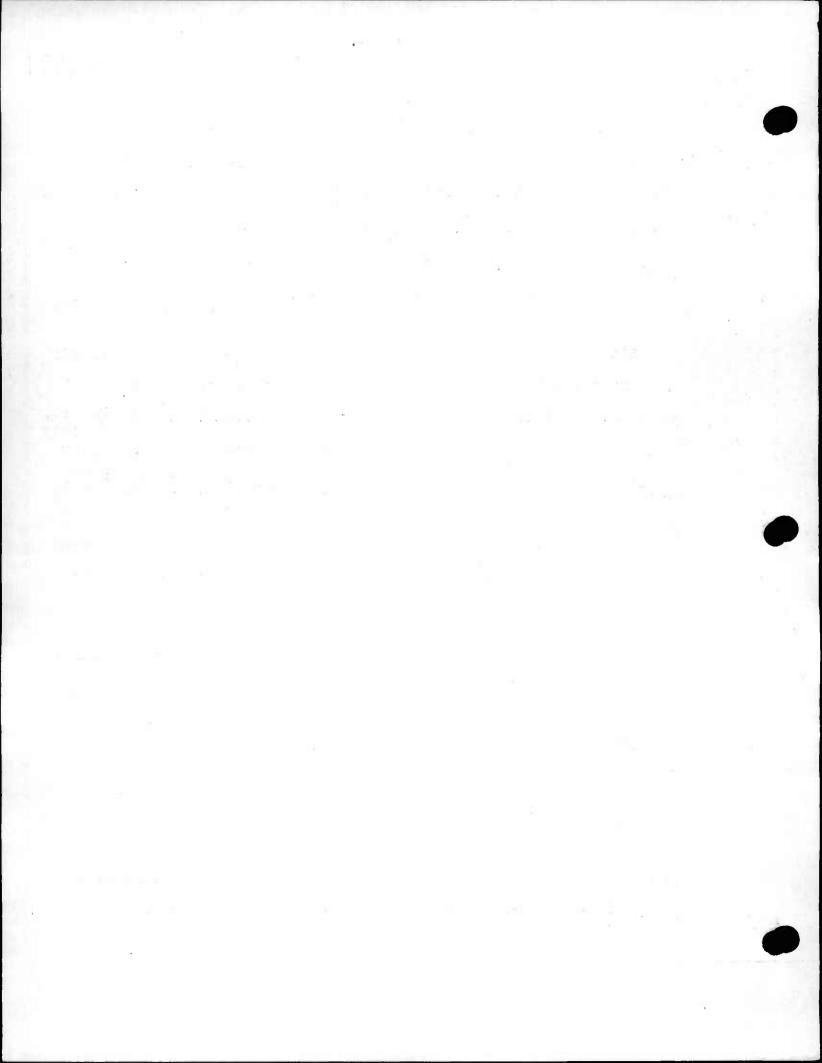
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlal-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlal, cremation, or removal.

IMPORTANT: It them 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

FOR

| | REGISTRAR | | CERTIFIC | CATE OF | DEATH | REG. | NO. | | |
|---|--|--|-------------------------------------|--------------------------------|--|---|-----------------------|----------------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Lust) SHIRLEY | ANN PEU | GH | | | 2. DATE OF DEATH | | YEAR | 3. TIME OF DEATH |
| | 214-44-0876 | □ M 2 12 F | 45 YRS. M | ONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH | - | Mary | yland |
| uo. | 98. FACILITY NAME (If not institution, give street 3612 Court House RESIDENCE OF DECEDENT | | | | cott Ci | | 7.1. 1.5.1. | lowai | rd County |
| | 10a. STATE 10b. COUNTY | ward Cou | | TOWN OR LOCAT | t City | | | | 10d. INSIDE CITY LIMITS? 1 X YES 2 NO |
| LINGE | 100. STREET AND NUMBER 3612 Court House | e Dr. Ap | t 1-A | 10f. | ZIP CODE 210 | 143 | 10g. CITI | ZEN OF WH | A COUNTRY? |
| | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | . WAS DECEDENT EVER FORCES? 1 YE IF YES, GIVE WAR OR | | If yes, spi | ENDENT OF HISPAN city Cuban, Maxica 2 A NO Specifi | IIC ORIGIN? (Specify n, Puarto Rican, atc. /: | Yas or No- | 14. RACE Black, Specify | - American Indian, White, atc. White |
| 1 | | ON spleted) college (1-4 or 5+) | life. Do NOT use | rk done during mo retired.) | N st of working | | BUSINESS/IND | 4 | |
| | 11th | | B1: | inder | | Londo | n Fog | ; Ou | terwear |
| 3 | 17. FATHER'S NAME (First, Middle, Lest) Harry Halbig | | | | | me (First, Middle, Me izabeth | | er | |
| | 190. INFORMANT'S NAME (Type/Print) Truman F. Peugh | jr | | | | | -A,E1 | lic | ott City |
| | 20e. METHOD OF DISPOSITION 1X Burtal 2 Cremation 3 Removal 4 Donation 9 Other (Specify) | 1 | Maryland | Veter | ans Cen | netery (| arris | son l | |
| | 21. HONATURE OF JUNEAU SERVICE LICENS | Slenk | M00535 | 22. NAME AP | Ellicot | CHITY Slack | Fune Mary | ral | Home d 21043 |
| | 23. PANT I. Enter the diseases, or com- ahock, or heart failure. List IMMEDIATE CAUSE (Final disease or condition | only one causa on | sed the death. Do no each line. | t entar the mo | de of dylng, auc | h as cardiac or r | papiratory arr | reat, | Approximate interval Between Onset and Death |
| | resulting in death) a | | S A CONSEQUENCE OF | 4 | | | | | 4mon4/1 |
| CALICIA | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | DUE TO (OR A | S A CONSEQUENCE OF) | Vis Virsis | | | | | 10000 |
| CENTILL | that initiated events resulting in death) LAST | OUE TO (OR A | S A CONSEQUENCE OF) | | | | | | |
| 1 | PART II. Other algnificant conditions of | ontributing to death | but not resulting in | the underlyin | cause given in | PE | AN AUTOPSY FORMED? | | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| . IMED | | | | | | _ 104 | S 2 NO | - 1 | OF DEATH? 1 YES 2 NO |
| SICIOIN | 25. WAS CASE REFERRED TO MEDICAL | | | 28. PI | ACE OF DEATH (C) | neck only one) | | | |
| 5 | | OSPITAL: | | OTHER: 4 Nursing Hom | e 5 Raaldenca | 8 Other (Specify) | | | |
| 111111111111111111111111111111111111111 | 27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation | 28s. DATE OF INJUR (Month, Day, Yes | | RY WC | URY AT PRK? YES 2 NO | 28d. DEŞCRIBE H | OO YRULNI WO | CURED | |
| | 3 Suicide 8 Could not be 4 Homicide detarmined | 28e. PLACE OF INJU building, etc. (S | JRY — At home, farm, st specify) | reet, factory, offic | • | 281. LOCATION (St City or Town, S | | r or Rurel Ro | oute Number, |
| COMPLEIED | 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: | _ | | | | | | | and menner as stated. |
| D DE | 295 SIGNATURE AND TITLE OF CERTIFIER | Simo | | | 29c. LICENSE NU D3850 | | | | (Month, Day, Year) |
| - | Nicholas Id Kon fro | 1 6 - 2 5 | DEATH (ITEM 27) (Type, I | Ferry P | | in buy Mel | 2104 | 4 | |
| | 31. DATE FILED (Months Day, 1990) | 32. REGISTRAR'S SI | | | | | | | |



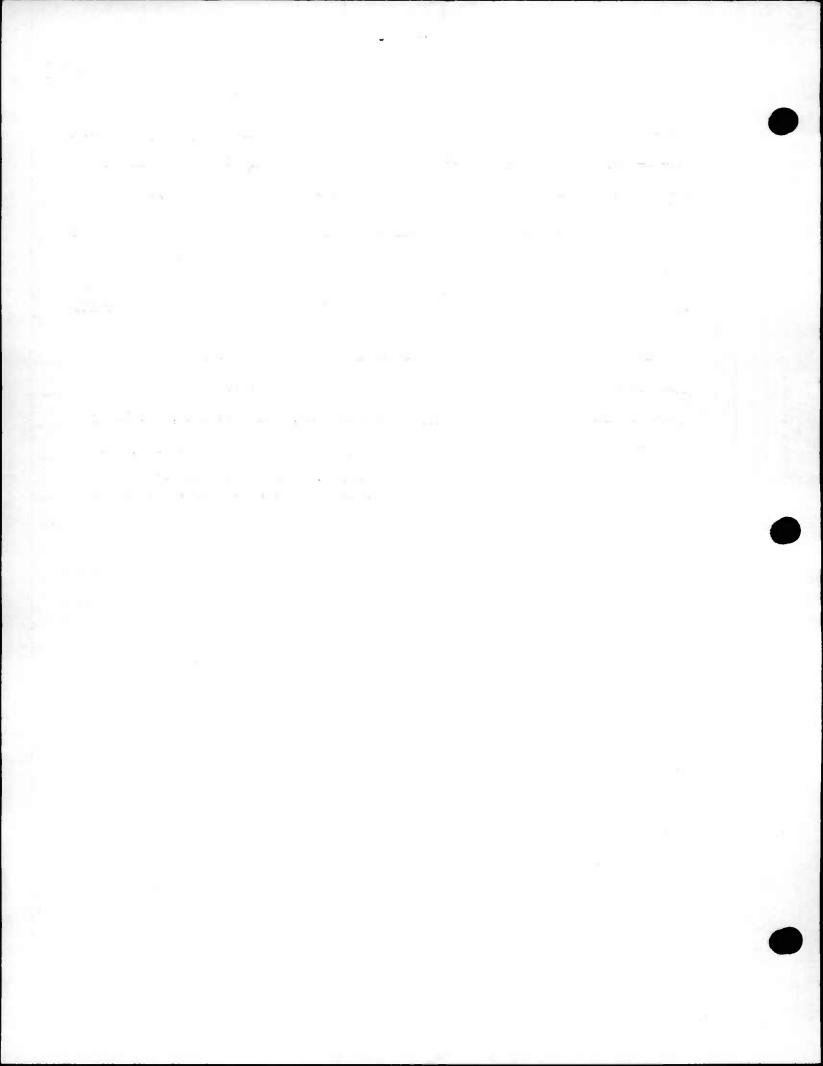


DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| A CETE COMPIETED B | TO BE COME ETED BY BUYCICIAM: MEDICAL CEDTICICATION |
|---|---|
| examiner must be notified at once. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
| ne funeral director, page 5 should be detached for use as the | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the |
| r death. Page 6 may be retained by the hospital or attending | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nous after death. Page 6 may be retained by the hospital or attending |
| | |

| STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL | HYGIENE |
|---|----------|
| CERTIFICATE OF DEATH | REG. NO. |

| 1. DECEDENT'S NAME (First, Middle, La | ot) | OLITIFIC | ATE OF DEATI | | REG. NO. | | 3. TIME OF DEATH |
|--|--|---|--|---|--|---|--|
| Martha Perl | | | | MONTH | | YEAR 90 | 12:25 A |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AC | | F UNDER 1 YEAR IF UNDER 24 | /0.0 | OF BIRTH | 8, BIRT | HPLACE (State or Foreign |
| 068-01-9087 | 1 M 2 XF | 88 YRS. | ONTHE DAYS HOURS | MIN. 1/2 | 26/02 | Pol | and |
| Se. FACILITY NAME (If not institution, gir | | 9 | b. CITY, TOWN OR LOCATION | N 1 | 96 | COUNTY OF | DEATH |
| Caton Manor Mur | sing Center | | Baltimore | City | | N/A | |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COU | NTY | 10c, CITY, | TOWN OR LOCATION | 1 | | | 10d. INSIDE CITY |
| Md. | Howard | Elli | cott City | | | | 1 YES 2 NO |
| 10s. STREET AND NUMBER | | 100 | 10f. ZIP CODE | | 10 | g. CITIZEN OF | WHAT COUNTRY? |
| 4730 Sheppard | Lane | | 210 | 043 | | | USA |
| 11. MARITAL STATUS | 12. WAS DECEDENT EVE FORCES? 1 \(\subseteq \text{Y} | R IN U.S. ARMED | 13. WAS DECENDENT OF If yes, specify Cuben, | | | No- 14. RAG | CE — American Indian, ck, Whita, etc. |
| 1 Never Married 2 Married 3 Widowed 4 Divorced | IF YES, GIVE WAR OF | R DATES | 1 TES 2 NO | | Thomas of the same | | white |
| 15. DECEDENT'S E | DUCATION | 184. DECEDENT'S US | BUAL OCCUPATION | 165 | . KIND OF BUSINE | SS/INDISTRY | WILL CE |
| (Specify only highest gr Elementary/Secondary (0-12) | | (Give kind of wor | k done during most of working | 1 100 | | | |
| 12 | consign (in or 57) | Hous | sewife | | Home | | |
| 17. FATHER'S NAME (First, Middle, Last) | | | 18. MOTHE | R'S NAME (First, I | Middle, Malden Surr | name) | |
| Mordechai Klep | fish | | Sar | ah Zucke | er | | |
| 19a. INFORMANT'S NAME (Type/Print) | - | | DORESS (Street and Number of | | | | |
| Lola P. Klein | | 4730 Sh | eppard Lane | , Ellico | | • | |
| 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 R | emoval from State | other place) | ION (Name of cemetery, creme | tory or | | ION — City or 1 | |
| 4 ☐ Donation 5 ☐ Other (Specify) 21. SIGNATURE OF PUNERAL SERVICE | . LOSSINGS | Metro (| rematory | | Balt | imore, | Md. |
| 21. SIGNATURE OF PURERAL SERVICE | LICENSEE | A | Gary L. K | | Funera. | Homes | |
| 1 1 4 | / / / | | | | | | |
| / Oller | 1 rou | men | 5695 Main | | | | 21227 |
| 23. PART T. Enter the discesses, | or complications that cau | sed the death. Do no | 5695 Main | St., E | lkridge, | Md. | Approximate |
| shock, or heart fally IMMEDIATE CAUSE (Final | or complications that cause. List only one ceuse of | sed the death. Do not n each line. | 5695 Main | St., E. | lkridge, | Md. | Approximata interval Batwe |
| shock, or heart fally | or complications that cause of course of course of course of cause | sed the death. Do not neech line. | 5695 Main | St., E. | lkridge, | Md. | Approximata interval Batwe |
| shock, or heert fally. IMMEDIATE CAUSE (Final disease or condition | a | sed the death. Do not neech line. | 5695 Main | St., E. | lkridge, | Md. | Approximate interval Batwee Onset and Dea |
| shock, or heert fally. IMMEDIATE CAUSE (Final disease or condition | a | AS A CONSEQUENCE OF): | 5695 Main tenter the mode of dyln | St., E. | lkridge, | Md. | Approximate interval Batwee Onset and Dea |
| iMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a | Capiral | 5695 Main tenter the mode of dyln | St., E. | lkridge, | Md. | Approximata interval Batwee Onset and Dea Stu |
| shock, or heert failule immediate cause or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a | AS A CONSEQUENCE OF): | 5695 Main tenter the mode of dyln | St., E. | lkridge, | Md. | Approximate interval Batwee Onset and Dea |
| shock, or heert failule immediate cause. Enter UNDERLYING | a | AS A CONSEQUENCE OF): | 5695 Main tenter the mode of dyln | St., E. | lkridge, | Md. | Approximata interval Batwee Onset and Dea Stu |
| shock, or heer failule immediate cause. Enter UNDERLYING CAUSE (Plises or injury that initiated events resulting in death) LAST | a | AS A CONSEQUENCE OF): US A CONSEQUENCE OF): US A CONSEQUENCE OF): | 5695 Main tenter the mode of dyin | St., E. | lkridge | Md. | Approximata interval Batwee Onset and Dea Stune 12 W S |
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| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOT | HER'S NA | ME (First, Mic | ddle, Maiden | Sumame) | | |
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| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the conditions of the conditio | DUE TO b. Lung DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Pay, Year) OF INJURY — At hetc. (Specify) | OUENCE OF C | OTHEF OTHER A Num NE OF JURY M street, fect | 26. Pl 3: sing Hon 28c. IN. W(1 ory, office | LACE OF 1 JURY AT DRK? YES 2 | DEATH (C) | 8 Other 28d. DESC | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | RMED? NO NO NO NO NO NO NO NO NO N | DOCCURED Der or Rural tated. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, |
| ED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the conditions of the conditio | DUE TO b. Lung DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Pay, Year) OF INJURY — At hetc. (Specify) | OUENCE OF C | OTHEF OTHER A Num NE OF JURY M street, fect | 26. Pl 3: sing Hon 28c. IN. W(1 ory, office | LACE OF 1 JURY AT DRK? YES 2 | DEATH (C) | 8 Other 28d. DESC | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | RMED? NO NO NO NO NO NO NO NO NO N | DOCCURED Der or Rural tated. | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO |
| BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER) | DUE TO b. Lung DUE TO c. DUE TO d. DUE TO d. HOSPITAL: 1XXInpetient 2 26e. DATE OF (Month, D. Duilding, | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Pay, Year) OF INJURY — At hetc. (Specify) | OUENCE OF C | OTHEF OTHER A Num NE OF JURY M street, fect | 26. Pl 3: sing Hon 28c. IN. W(1 ory, office | LACE OF 1 ne 5 | DEATH (C) lesidence NO No | 8 Other 28d. DESC 28f. LOCA City o | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | INJURY O | per or Rural | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO I Route Number, |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the conditions of the conditio | DUE TO b. Lung DUE TO c. DUE TO d. DUE TO d. HOSPITAL: 1XXInpetient 2 26e. DATE OF (Month, D. Duilding, | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Pay, Year) OF INJURY — At hetc. (Specify) | OUENCE OF C | OTHEF OTHER A Num NE OF JURY M street, fect | 26. Pl 3: sing Hon 28c. IN. W(1 ory, office | LACE OF 1 ne 5 | DEATH (C) | 8 Other 28d. DESC 28f. LOCA City o | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | INJURY O | per or Rural | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER) | DUE TO b. Lung DUE TO c. DUE TO d. DUE TO d. HOSPITAL: 1XXInpetient 2 26e. DATE OF (Month, D. Duilding, | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Pay, Year) OF INJURY — At hetc. (Specify) | OUENCE OF C | OTHEF OTHER A Num NE OF JURY M street, fect | 26. Pl 3: sing Hon 28c. IN. W(1 ory, office | LACE OF 1 ne 5 | DEATH (C) lesidence NO No | 8 Other 28d. DESC 28f. LOCA City o | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | INJURY O | course or Aural tated. The cause ATE SIGNE | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Route Number, (e) end menner es stated. |
| E COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER 29b. SIGNATURE AND TITLE OF CERTIFIER | DUE TO b. LUING DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS | OUENCE COUENCE | OTHEF OTHER A DAN NE OF JUNY M atreef, fact | 26. Pi 3: sing Hon 28c. IN. WC 1 Ory, office Ime, date | LACE OF 1 Ine 5 R JURY AT DRIX? YES 2 De end plec death occur 29c. LIC | DEATH (Chilesidence NO NO NO NO NO NO NO NO NO NO NO NO NO | s Other 28d. DESC 28f. LOCA City o | PERFOI 1 VES : (Specify) RIBE HOW TION (Street rown, State) | SINJURY O | tated. ATE SIGNE | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, (e) end menner es stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the cause of the conditions of the cause | DUE TO b. Lung DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Toy, Year) OF INJURY — At hetc. (Specify) If my knowledge, department of the consensation end/or the con | OUENCE COUENCE | OTHEF OTHER A DAN NE OF JUNY M atreef, fact | 26. Pi | LACE OF 1 IN 5 R JURY AT PRK? YES 2 Dee a end place death occur 29c. LIC | DEATH (Charles desidence No No No No No No No No No No No No No | eck only one 6 Other 26d. DESC 28f. LOCA City o | PERFOID (Specify) CRIBE HOW TION (Street r Town, State) LE Medical Place, etc. | and Numb | tated. The cause ATE SIGNE 21 N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, (e) end menner es stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the cause of the conditions of the cause | DUE TO b. Lung DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS | OUENCE COUENCE | OTHEF OTHER A DAN NE OF JUNY M atreef, fact | 26. Pi | LACE OF 1 IN 5 R JURY AT PRK? YES 2 Dee a end place death occur 29c. LIC | DEATH (Charles desidence No No No No No No No No No No No No No | s Other 28d. DESC 28f. LOCA City o | PERFOID (Specify) CRIBE HOW TION (Street r Town, State) LE Medical Place, etc. | and Numb | tated. The cause ATE SIGNE 21 N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, (e) end menner es stated. |
| BE COMPLETED BY PHYSICIAN: MEDICAL | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST PART II. Other algnificant conditions and the cause of the conditions of the cause | DUE TO b. LUING DUE TO c. DUE TO d | CANCET (OR AS A CONSE (OR AS A CONSE (OR AS A CONSE death but not ER/Outpatient FINJURY Toy, Year) OF INJURY — At hetc. (Specify) If my knowledge, department of the consensation end/or the con | OUENCE OF COUNTY OF COUNTY | OTHEF OTHER A DAN NE OF JUNY M atreef, fact | 26. Pi | LACE OF 1 IN 5 R JURY AT PRK? YES 2 Dee a end place death occur 29c. LIC | DEATH (Charles desidence No No No No No No No No No No No No No | eck only one 6 Other 26d. DESC 28f. LOCA City o | PERFOID (Specify) CRIBE HOW TION (Street r Town, State) LE Medical Place, etc. | and Numb | tated. The cause ATE SIGNE 21 N | AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO Floute Number, (e) end menner es stated. |

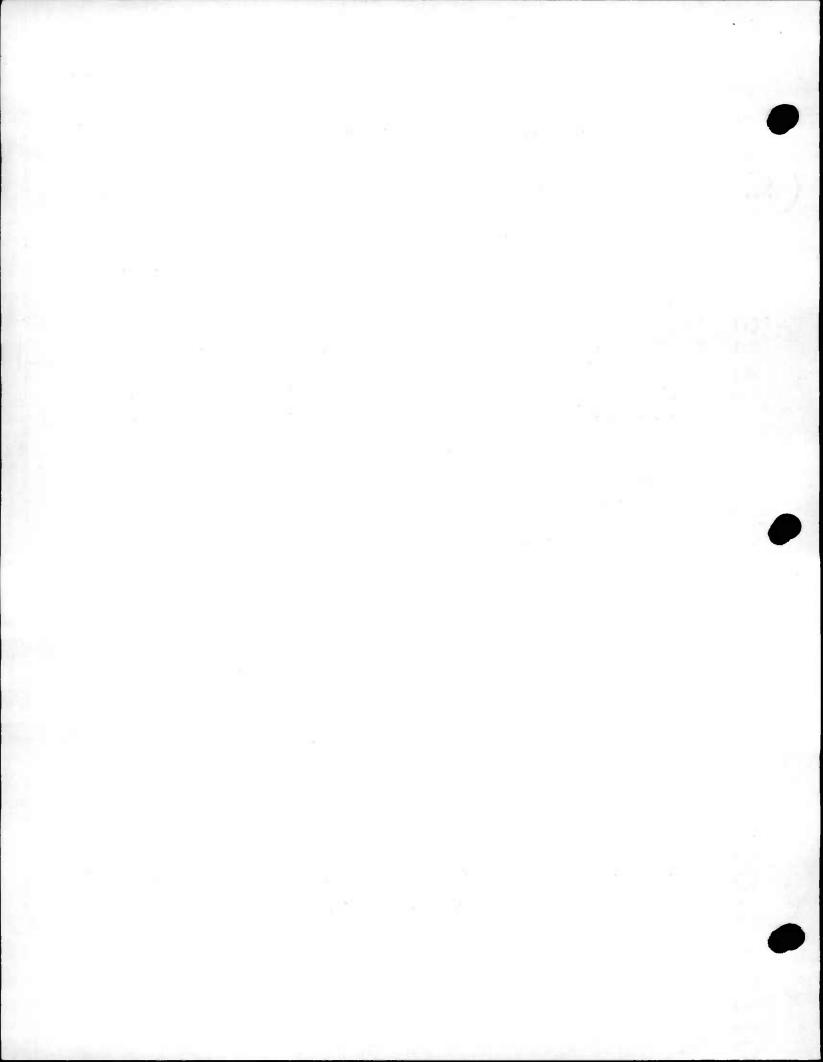
BALTIMORE, MARYLAND 21203-3146 DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 2- nours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYL | | | OF DEATH | | REG. NO. | | |
|--|---|------------------------|---------------|-------------------------|------------|---|---------------|--|
| 1. OECEDENT'S NAME (First, Middle, Last) | , | | 0 | | | 2. DATE OF DEATH | | 3. TIME OF DEATH |
| Corri | ne to | 1115e | fay | re | | MONTH 23 DA | -90 | EAR 839 M |
| 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| In yrs. last birthday) | IF UNDER 1 | | HRS. 7 | Month Day Mar | 0. | BIRTHPLACE (State or Foreign |
| 577-01-9099 | 1 M 2 K F 79 | YRS. | MONTHS | DAYS HOURS | MIN. | arch 20, | 1911 | country) irginia |
| 9a. FACILITY NAME (If not institution, give str | | | | TOWN OR LOCATION | | Н | | OF DEATH |
| 710 Buckmaster La | ane | | Fort | Washingt | on | | Princ | e George's |
| RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | T 400 CI2 | Y, TOWN OR | LOCATION | | | | Land manage disease |
| | | 1.0 | | | | | | 10d. INSIDE CITY LIMITS? |
| Maryland Prince | e George's | FC | ort Wa | shington | | | 40. 017176 | 1 ☐ YES 2 🔯 NO N OF WHAT COUNTRY? |
| | • | | | | , , , | | | |
| 3608 Chandler Dr: | LVE 12. WAS DECEDENT EVER IN | LUC ADMED | 40.196 | 207 | | ORIGIN? (Specify Yea | U.S | |
| 1 Never Married 2 Married 3 Wildowed 4 Divorced | FORCES? 1 YES | 2 X NO | - 11 | yes, specify Cuban, | | | OF NO. | RACE — American Indian, Black, Whita, etc. Specifichite |
| 15. DECEDENT'S EDUC. (Specify only highest grade of | | 16a. DECEDENT'S | USUAL OCC | CUPATION | | 166. KIND OF BUS | INESS/INDUS | TRY |
| Elementary/Secondary (0-12) | College (1-4 or 5+) | ilfe. Do NOT u | se retired.) | uring most of working | | | | |
| 9 | | Telepho | one Op | erator | | C & P 7 | eleph | one Company |
| 17. FATHER'S NAME (First, Middle, Last) | | 107 | | 18. MOTHE | R'S NAME | (First, Middle, Maiden | Sumame) | |
| John Q. Brown | | | | S | ally | Blankent | aker | |
| 19a. INFORMANT'S NAME (Type/Print) | | | | | | ute Number, City or Town | | |
| Robert Chick Pays | ne | 3608 0 | Chand1 | Ler Dr. F | t. W | <i>l</i> ashington | , Md. | 20744 |
| 20a. METHOO OF DISPOSITION 11 Burlal 2 Cremation 3 Remo | val from State | other piece) | | ne of cemetery, cremat | tory or | | | y or Town, Stata |
| 4 Donation 75 Other (Specify) | | Cedar Hi | | | | | | Maryland |
| 21. SIGNATURE OF FUNERAL SERVICE LIGH | 5/// | | 22. 0 | AME AND ADDRESS | OE FACE | as Funera | 1 Home | P |
| - There | ralps | | | | | 1 Rd. Oxo | | |
| ahock, or heart fellure. L IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS A | |)F): | * lerder 1 | lan | cules de | islar. | Interval Between Onset and Daeth |
| PART II. Other algnificent conditions | contributing to deeth b | ut not resulting | In the und | derlying cause gl | ven in Pr | art I. 24a. WAS AN PERFOR | MED? | 24b. WERE AUTOPSY FINDINGS AMALABLE PRIOR TO COMPLETION DF CAUSE DF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINERT | HOSPITAL: | | OTHER | 26. PLACE OF DE | ATH (Checi | k only one) | | |
| 1 Pres 2 □ NO | 1 Inputient 2 ER/Outp | | 4 🗆 Nural | ing Home 5 Aesi | | | | |
| 1 Natural 5 Pending | (Month, Day, Year) | 26b. TIII | ME OF JURY | 26c. INJURY AT WORK? | | RIId. DESCRIBE HOW I | NJURY OCCU | HED |
| 2 Accident Investigation | 200 01 100 05 11 | AL FINE CO. | M . | 1 YES 2 | - | | Lane : | |
| 3 Suicide 6 Could not be determined | 26e. PLACE OF INJURY building, etc. (Spec | — At nome, farm, city) | street, facto | ry, office | | 261. LOCATION (Street a City or Town, State) | and Number or | Rurel Route Number, |
| (orloan only | CIAN: To the best of my known: On the basis of examination | | | | | | | cause(a) and manner as stated. |
| 290. BUSHATURE AND TITLE OF CERTIFIER | 7 | 7 | | 29c. LICEN | ISE NUMB | EA | 29d. DATE S | SIGNEO (Month, Day, Year) |
| Hugusto Y. You | liging WV | / | | 03 | 12. | 30 | > //- | -13-90 |
| MULLISTO PROBLEMS | Labor non A | ATH (ITEM 27) (Type | o, Print) | press Cf | .Ep. | Son Me | 207 | 48 |
| 31. DATE FILED (Month, Day, Year) | 32. REGISTRAR'S SIGN | 10.0 | 1 | | 1 | V | | |



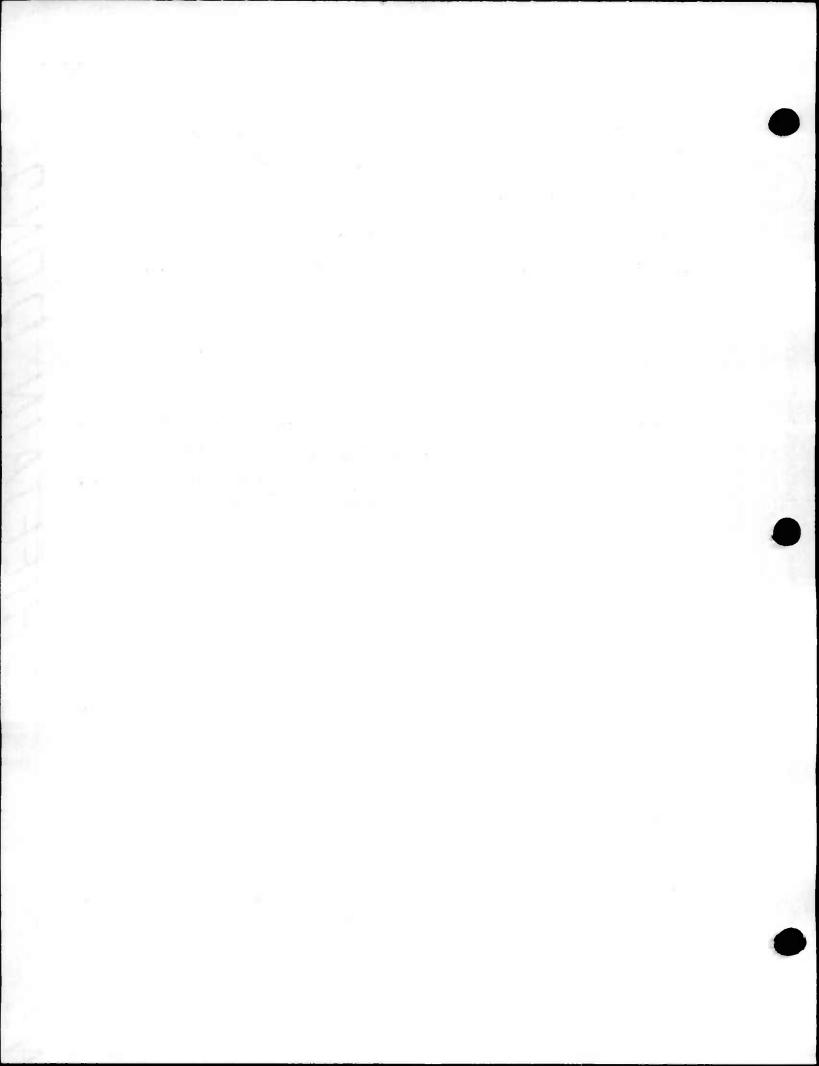
TO BE COMPLETED BY FUNERAL DIRECTOR

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detact he find within 72 hours after neath with the State Deor, of Health and Mental Hyplene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once | |
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| ained | should | iffed | |
| De ret | e 5 | 2 | |
| nay t | , pag | i p | |
| e 6 r | rector | Ē | |
| Pag. | 등 | ine | |
| death | fune | ехап | |
| after | noval | cal | |
| Surs | d in b | Ted. | |
| В | filler tion, | the | |
| vithin | rema | ar, | |
| y petr | comp rial, c | S ev | |
| exect | and or | mati | |
| e pe | sician prior 1 | tra | |
| tificat | phy ene | the | |
| n cer | Hygi | 0 10 | |
| deat | e atte | Ä, | |
| it the | Pd th | = | |
| s tha | afth a | am | |
| aduire | en sig | NO. | |
| J ME | ent. | 23 \$ | |
| The | ate Date | E | |
| SIAN: | he St | 10 | |
| HYSI | his ce | s marked, or item 2: | |
| NG P | fter th | шал | |
| ENDI | DR: A | 99 | |
| A ATT | RECTO | E 2 | |
| AL OF | L Dif | 5 | |
| SPIT | NERA hin Z | Ē | |
| E H | E FU | F | |
| TH O | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fur- he find within 72 hours after death with the State Deot: of Health and Mental Hydlene prior to burial, cremation, or removal. | MPO | |
| - | - 4 | - | |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - FOR STATE REGISTRAR | | STATE OF N | | D / DEPAR | | | | | MENT | AL HYGIEN REG. NO. | E | 20 | 04410 |
|---|-------------------------|------------------------------|----------------|--------------------------------|-------------|-------------|---------------------|----------------------|------------------|----------------------------------|---------------------------|-------------------|---|
| 1. DECEDENT'S NAME (First, | Middle, Las | st) | - | | | | | | 2. DA | TE OF DEATH | DAY YEAR 3. TIME OF DEATH | | |
| ТО | NY | VALDEZ | POI | TS | | | | | | | Ï990 | TEAT | 1:30 AM M |
| 4. SOCIAL SECURITY NUMB | ER | 5. SEX | 6. AGE (In yrs | s. lest birthday) | IF UNDER | DAYS | IF UNDER | | 7. DAT | E OF BIRTH with, Day, Year) | | 6. BIRTI Count | HPLACE (State or Foreign |
| N/A | | 1 🔀 M 2 🗆 F | XX. | XXX YRS. | XX | XN | 10° | 05 | 11 | -03-90 | | | yland |
| 9a. FACILITY NAME (If not in | | , | | | 9b. CITY | , TOWN | OR LOCATION | ON OF DE | EATH | | 9c. COU | INTY OF E | DEATH |
| Prince (| Georg | e's Hospit | al | | C | heve | rly, | | | | Prin | ce G | eorge's |
| 10a. STATE | 10b. COU | NTY | | 10c. CIT | ry, town | OR LOCA | TION | | | | | | 10d, INSIDE CITY |
| MD | В | altimore | | | Balt | imor | e | | | | | | LIMITS? |
| 10e. STREET AND NUMBER | | | | | | | . ZIP CODI | E | | | 10g. CIT | IZEN OF | WHAT COUNTRY? |
| 1270 Wood | lbour | ne Ave | ξA1 | | | | 2123 | 9 | | | II | .S.A | |
| 11. MARITAL STATUS | | 12. WAS DECEDEN FORCES? 1 | | ARMED | 13. | WAS DEC | ENDENT C | F HISPAI | NIC ORIG | GIN? (Specify Yes | or No- | 14. RAC | E — American Indian, k, Whita, atc. |
| 1 Never Married 2 3 Widowed 4 Divo | | IF YES, GIVE W | AR OR DATES | AMO | | 1 YES | 2 XXVIO | in, Maxica Specif | in, Pueri ly: | o Rican, atc.) | | Spec | |
| | | | | | | | | | | | | _ | ack |
| (Specify only | | ade completed) | 16a | Give kind of life. Do NOT u | work done | during me | ON ast of worldr | ng | 1 | 6b. KIND OF BUS | SINESS/INI | DUSTRY | |
| Elementery/Secondery (0 | -12) | N/A |) | | , | | | | | 37 / | | | |
| N/A | iririle net) | N/A | | Ini | ant | | 10 MOT | HED'C NA | ME /E/m | N/ | | | |
| Thon | - 11 | Potts | | | | | | | | Richard | | | |
| 19a. INFORMANT'S NAME (7) | | 10113 | | 19b. MAILING | G ADDRES | S (Street) | | | | imber, City or Tow | | In Code) | |
| Aretha H | | rdson | | | | | | | | | | | D 21239 |
| 20a. METHOD OF DISPOSITI | | | 20b. PL/ | ACE OF DISPO | | | | | // FA | | | | own, Stata |
| 1 Burial 2XXCremation 4 Donation 6 0 Other | | emoval from Stata | | _{er place)} edar H | :11 | Crom | 2 + 017 | | | | t1an | | |
| 21. SIGNATURE OF FUNERA | L SERVICE | LICENSEE | | edar_u | | | ND ADDRE | | CILITY | | Lian | CL PI | <u></u> |
| > Veclar | // | (Plan | | | | | | | | | | | e, P.A. |
| 23. PART I. Enter the d | | or complications the | t caused the | death Do | not enter | 9013 | Ann | apo1 | is | Rd., La | nham | MD | 20706 Approximats |
| shock, or he IMMEDIATE CAUSE (Fir disease or condition resulting in death) | eart fallu | s. August | se on sach | lins. | | Fre | ESI | | | | | | Interval Between Onset and Death |
| Sequentisity list condition if sny, leading to imme cause. Enter UNDERLY CAUSE (Disease or injust that initiated events resulting in death) LAS | diats ING Iry | C | | NSEQUENCE C | | MA | TUR | V7, | Ψ | | | | |
| PART II. Other algorifica | nt condit | lona contributing to | death but n | ot reaulting | In the u | ndsrlyln | g cause | given in | Part I. | 24a. WAS AN PERFOR 1 YES 2 | RMED? | 241 | D. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| 25. WAS CASE REFERRED TO | D MEDICAL | | - | | | | ACE OF T | EATH M | hank* | 1 | | | NIH |
| EXAMINER? | - MEDICAL | HOSPITAL: | en/o | 4 | OTHE | R: | LACE OF D | | | | | | , |
| 27. MANNER OF DEATH | | 1 Inpatient 2 | | 1 3 DOA | | | URY AT | esidence | Y | ther (Specify) DESCRIBE HOW I | N.IUPY O | CHBED | |
| | Pending | (Month, D | | | JURY M | W | PRK? | NO | 100.0 | PEQUINDE HOW I | mooni oc | JOUNED | |
| 2 Outside | Investigation | 28e. PLACE O | F INJURY — A | M home, farm, | street, fec | | | | 26f. L | OCATION (Street | and Numbe | or or Rural | Route Number. |
| | Could not datarmined | building. | atc. (Specify) | | | | | | C | ity or Town, State) | | | , |
| 29a, CERTIFIER 1 CERT | DEVING PH | IYSICIAN: To the best of | my knowledge | a death occur | rad at the | time des | and place | and de- | to the | councils) and man | nner en ch | nted | |
| | | | | | | | | | | | | | a) end manner as stated. |
| 29b. SIGNATURE AND TITLE | OF CERTI | FIER / D | | مار | i | P | 29c. LIC | ENSE NU | MBER | | | | 0 (Month, Day, Year) |
| 30 NAME AND ADDRESS OF | - | WHO COMPLETED CAU | SE OF DEATH | (ITEM 27) (Typ | e, Print) | | | | - | 's Com | | | |
| TIA | Ybar) | 0 32 REGISTRA | R'S SIGNATUI | RE . | MI | CI | ever | ·1y, | Mar | yland | | | |
| MON 5 9 . 30 | | Julia Davidson | -Randa | | | | | | | | | | |



600 N WOLFE

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

DEC 04 1990

| 200 | detac | | Once |
|--|---|--------|---|
| 5 | 2 | | at |
| TO THE HOSPITAL OR ATTENDING PHYSICIAN; The law requires that the death centinicate be executed within 24 mouts after death; rage of may be retained by the fire | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detac | | authorization 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once |
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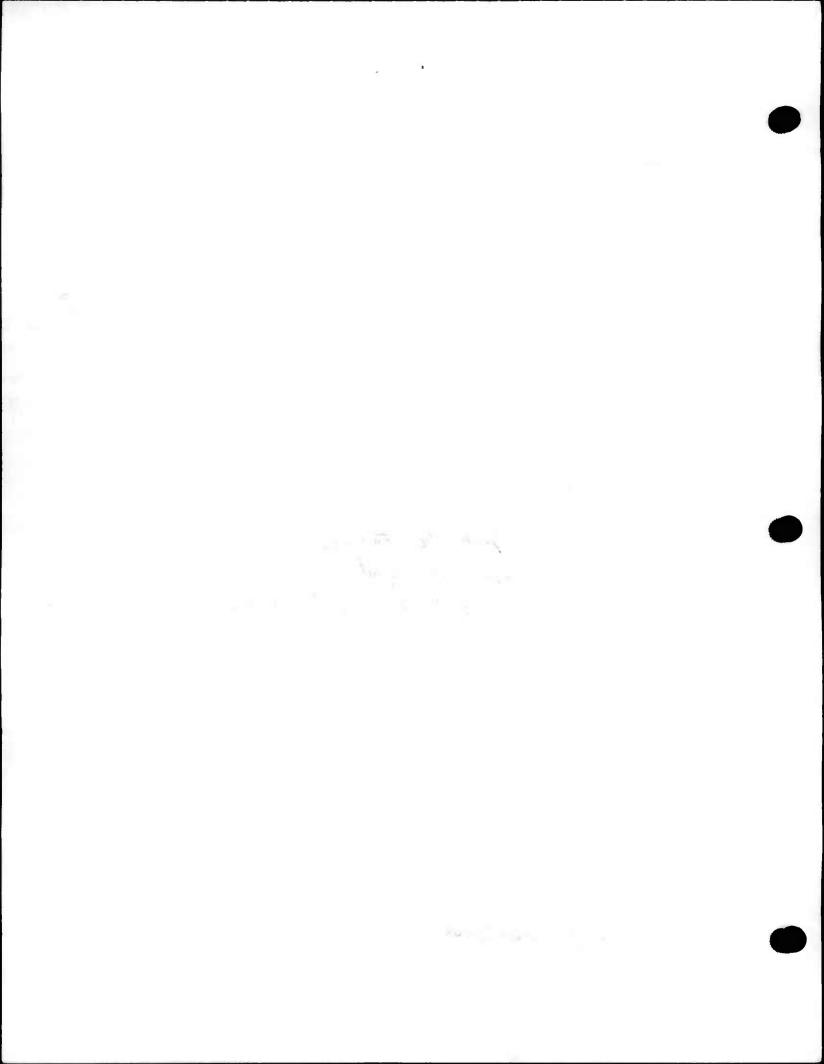
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| | STATE OF MARYL | AND / DEPAR | TMENT OF H | FAITH AND M | ENTAL H | YGIENE | | | 04470 |
| | 1 - STATE REGISTRAR | CERTIFI | CATE OF | DEATH | | G. NO. | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 1 | 2. DATE OF D MONTH | EATH DAY | | YEAR | 3. TIME OF DEATH |
| | KATHLEEN PETERSON 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (| In yrs. last birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF B | | 90 | A BIRTHP | 03:56 P M |
| | 1 □ M 2 및 F | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day | Year) | an l | Country) | MD |
| | Se. FACILITY NAME (If not institution, give street and number) | | 9b. CITY, TOWN O | R LOCATION OF DEAT | | | | | |
| OR | THE JOHNS HOPKINS HOSPITAL | | BALTIM | ORE CITY | | BAL | TIMOR | E CITY | |
| DIRECTOR | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | 10c. CITY | , TOWN OR LOCAT | ION | | | 1-1-1-1 | | 10d. INSIDE CITY |
| DIR | MD Anne Arundel | Se | verna Pa | rk | | | | | LIMITS? |
| | 10e. STREET AND NUMBER | | 101 | . ZIP CODE | | T | 10g. CITI | ZEN OF WI | IAT COUNTRY? |
| FUNERAL | 926 Ryecroft Ct. | | | 21146 | | | U. | S.A. | |
| E | 11. MARITAL STATUS 1 X Never Married 12. WAS DECEDENT EVER III FORCES? 1 YES | | | ENDENT OF HISPANIC | | | or No— | 14. RACE - Black, | - American Indian, White, atc. |
| ВУ | 3 Wildowed 4 Divorced IF YES, GIVE WAR OR DA | ATES | 1 🗆 YES | 2 NO Specify: | | | | Specify | White |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) | | USUAL OCCUPATIO | | 16b. KIN | D OF BUSI | NESS/INC | DUSTRY | |
| 삘 | Elementary/Secondary (0-12) College (1-4 or 5 +) | life. Do NOT us | e retired.) | st or working | | | | | |
| COMPLETED | | | | | | | | | - |
| 응 | 17. FATHER'S NAME (First, Middle, Last) David Noel Peter | con | | 18. MOTHER'S NAMI | | | _{umame)} niga | | |
| B | De VIG NOEI PECEI 190. INFORMANT'S NAME (Type/Print) | | ADDRESS (Street e | nd Number or Rural Ro | | | | | |
| ٩ | David Peterson | rna Pa | | | | | | | |
| | | SITION (Name of cen | | | | | City or Tow | rn, Slate | |
| | 4 Donation 5 Other (Specify) | other place) | | Cemetery | | Ann | apo1 | is, N | 4D |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE | | | ND ADDRESS OF FACI | | | | | e Hwy. |
| | Joseph Bance | | Barrar | nco Funera | al Hon | ne Se | vern | ia Pai | rk Md 21146 |
| | 23. PART I Enter the diseases, or complications that cause ahock, or heart failure. List only one cause on a | | not enter the mo | de of dying, such | aa cardiac | or reapin | atory an | reat, | Approximate Interval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | 1 /400 | 77.1. | ~ | | | | | Onset and Death |
| | reaulting in death) e. Due to on as | A CONSEQUENCE OF | FA LULE | | | | Ihr | | |
| , | 5/P | Coreval | MELTY B | lyraic | | | | | 2 H25 |
| ERTIFICATION | Sequentially list conditions, If any, leading to immediate | A CONSEQUENCE OF | | 1 | n | | | | 0 |
| CA. | cause. Enter UNDERLYING CAUSE (Disease or injury | earl C | Colaby | with mos | welley | | | | domos |
| 불 | that initiated events reculting in death) LAST | A CONSEQUENCE OF | F): | | | | | | |
| CEF | | | | | | | | | + |
| AL | PART II. Other aignificant conditions contributing to death t | but not resulting | in the underlyin | g cause given in P | Part I. 24 | PERFORI | | , | WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO |
| EDICAL | | | | | _ 10 | YES 2 | NO | | COMPLETION OF CAUSE OF DEATH? |
| ME | | | | | | | | | 1 TYES 2 DINO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 26. P | LACE OF DEATH (Chec | ck only one) | | | | |
| SIC | EXAMINER? HOSPITAL: 1 YES 2 NO 1 Inpatient 2 ER/Out | patient 3 DOA | OTHER: | ne 5 🗆 Residence 8 | Other (Sc | ecify) | | | |
| PHYSICIAN | 27. MANNER OF DEATH 28e. DATE OF INJURY (Month, Day, Year) | 28b. TIN | | JURY AT ORK? | 28d. DESCRI | BE HOW IN | JURY OC | CURED | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | M 1 🗆 | YES 2 NO | | | | | |
| 8 | 3 Suicide 8 Could not be 4 Homicide determined 28e. PLACE OF INJUR' building, etc. (Spe | | street, factory, offic | 00 | City or To | N (Street a wn, State) | nd Numbe | or Runai R | oute Number, |
| LET. | 290. CERTIFIER 1 ERTIFYING PHYSICIAN: To the best of my know | eledon, death occur | ad at the lime date | and place and due to | to the causes | a) and men | ner se se | ted: | |
| COMPL | (Check only one) 2 MEDICAL EXAMINER: On the basic of examination | | | | | | | | end menner ee stated. |
| 00 | 29b. SIGNATURE AND TITLE OF CERTIFIER, / / | | | 29c. LICENSE NUMI | | | 29d. DA | TE SIGNED | (Month, Day, Year) |
| 8 | vimos to the L | 1 | | 13/64 | / | | | 10/2 | 3/90 |

29c. LICENSE NUMBER
03/64/

Baltings as

29d. DATE SIGNED (Mornin, Day, Year)

11/23/90



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. DIVISION OF VITAL RECORDS, P.O. BOX 13146,

FOR

| | 1 - STATE REGISTRAR | | CERTIFICA | ATE OF DEATH | REG. NO. | | | | | |
|---------------|--|---|--|---|--|----------------------------------|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) SAMUEL | F. | PURBY | | 2. DATE OF DEATH DA | 5-90 | 3. TIME OF DEATH A | | | |
| | 4. SOCIAL SECURITY NUMBER 214-05-0198 9s. FACILITY NAME (# not institution, give s | 1 M 2 🗆 F | 83 YAS. MON | UNDER 1 YEAR IF UNDER 24 HRS. ITHS DAYS HOURS MIN. CITY, TOWN OR LOCATION OF DI | 7. DATE OF BIRTH (Month, Day, Year) 0 9 - 0 1 - 0 7 | Counti | imore, MD | | | |
| TOR | Anne Arundel M RESIDENCE OF DECEDENT | | | | | | | | | |
| DIRECTOR | | Arundel | | ONN OR LOCATION | | | 10d. INSIDE CITY LIMITS? X[X YES 2 NO | | | |
| FUNERAL | 300 Forbes St | | | 21401 | | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUI | 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER FORCES? 1 YE YE IF YES, GIVE WAR OR | ES 2 NO DATES | 13. WAS DECENDENT OF HISPAI It yes, specify Cuben, Maxico 1 YES 2 NO Specif | n, Pusrto Rican, stc.) | or No— 14. RACI Bleck Spec | E — American Indian, k, White, stc. #y: White | | | |
| TED | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 18s. DECEDENT'S USU | done during most of working | 16b, KIND OF BUS | SINESS/INDUSTRY | WILLOC | | | |
| COMPLETED | Elementary/Secondary (0-12) | College (1-4 or 5+) | Owner | 'Manager | Resta | aurant | | | | |
| BE CC | Samuel Purdy | | | Addie | Butler | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) Marian B ray P | urdy | | oness (Street and Number or Rural Orbes Street | . Annapo | lis. MD | | | | |
| | 20a. METNOD OF DISPOSITION 1 Burlai 2 Cremation 3 Tremayal from State 4 Donation sX Other (Specify) TO Office III Company Co | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LIE | Harde | oles | 22. NAME AND ADDRESS OF FU Hardesty Fu 12 Ridgely | ineral Ho Avenue, | me, P.A Annapol | is,MD | | | |
| | 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Ather sclerate Green As . Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): | | | | | | | | | |
| EDICAL | PART II. Other significent conditions contributing to deeth but not resulting in the underlying cause given in Part i. Consider rowl fixebeer. Copi All According 1 yes 2 NO 24b. WERE AUTOPSY FINDINGS ANALIBLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO | | | | | | | | | |
| PHYSICIAN: M | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | HOSPITAL: | | 28. PLACE OF DEATN (C | | | | | | |
| ву рну | 27. MANNER OF DEATH 1 Neturel 5 Pending 2 Accident Investigation | 28s. DATE OF INJUI (Month, Day, Yea | RY 285. TIME O | | 28d. DESCRIBE HOW | NJURY OCCURED | | | | |
| | 3 Suicide 8 Could not be 4 Homicide determined | 28e. PLACE OF INJU building, etc. (5 | URY — At home, farm, stree Specify) | nt, factory, office | 26t. LOCATION (Street City or Town, State) | and Number or Rural) | Route Number, | | | |
| COMPLETED | (Orlock only / | | | t the time, dats and place, and du n my opinion, death occured at th | | | s) and menner as stated. | | | |
| TO BE C | 29b. SIGNATURE AND TITLE OF CENTRAL | in i | 14) | 29c. LICENSE NU 23/ | HER TO THE PERSON OF THE PERSO | ≥ iv/5 | D (Month, Dey, Year) | | | |
| - | 30. NAME AND ADDRESS OF PERSON WI | IH INS, A | 1.D. 25 | SHOW ST | ANNO | OCUS, M | 11.21401 | | | |
| | 31. DATE FILED (Month, Day, Year) DEC 0 6 199 | 32. REGISTRÁR'S S Julia Davids | on-Randelle | | | | | | | |

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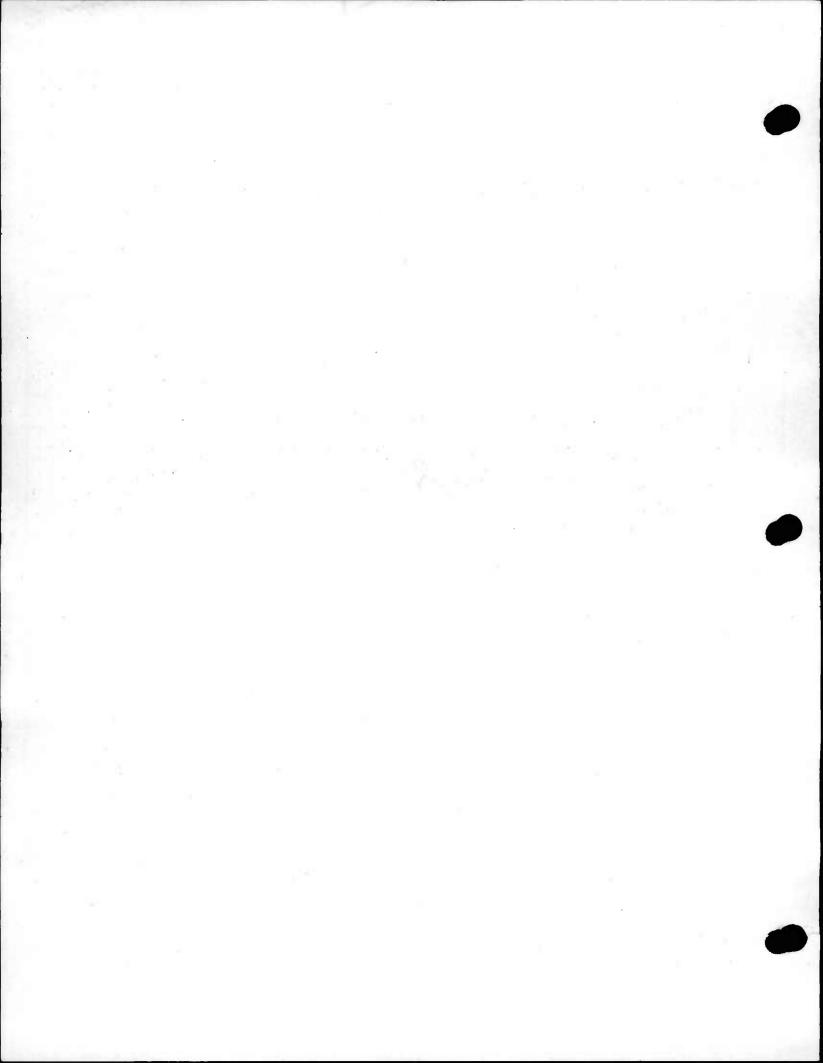
FOR STATE REGISTRAR CERTIFICATE OF DEATH REG NO 1. DECEDENT'S NAME (First, Middle, Last) 3. TIME OF DEATH 2. DATE OF DEATH DAY YEAR RUTH ROGERS 1990 DECEMBER 2 4. SOCIAL SECURITY NUMBER 5. SEX IF UNDER 1 YEAR IF UNDER 24 HRS. 7. OATE OF BIRTH (Month, Day, Year) 6. AGE (In yrs. last birthday) 8. BIRTHPLACE (State or Form 84 NEW JERSEY 214-28-3448 1 - M 2 X F MAY 13,1906 9e. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF OEATH 9c. COUNTY OF DEATH OR WICOMICO PENINSULA GENERAL HOSPITAL SALISBURY, MD RESIDENCE OF DECEDENT DIRECT 10e. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY THE PER 2 NO SALTSBURY MD. WICOMICO 10e. STREET AND NUMBER 10f. ZIP CODE FUNERAL 10g CITIZEN OF WHAT COUNTRY? U.S.A. 21801 518 WINDER STREET, RIVERSIDE HOMES 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 13. YAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No-11. MARITAL STATUS 14. RACE — American Indian, Bleck, White, etc. If yes, specify Cuben, Mexicen, Puerto Rican, etc.)

1 YES 2 NO Specify: 1 Never Merried 2 Married WHITE Specify: ВУ 3 Widowed 4 Divorced 9 15. DECEDENT'S EDUCATION 16e. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INCUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) ET Elementary/Secondary (0-12) College (1-4 or 5+) COMPL DEPT. STORE 10 SALESLADY 17. FATHER'S NAME (First, Middle, Lest) 18. MOTHER'S NAME (First, Middle, Maiden Surname) EMILIE SAEMANN HARRY F. STALDER BE 19e. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 RT.#2,BOX 36, PRINCESS ANNE, MD. 21853 JACQUELINE BOUNDS 20e. METHOD OF DISPOSITION
1 Suriel 2 Cremetion 3 1 1
4 Donation 5 0 Offer (Specify) 20b. PLACE OF DISPOSITION (Name of cametery, crematory or other place) 20c. LOCATION - City or Town, State 3 Removal from State FELLOWS CEMETERY MEDFORD, NEW JERSEY ODD 21. SIGNATURE OF THE HAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Buala 705 E. MAIN ST. dune BOUNDS FUNERAL HOME, SALISBURY, MD. 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory streat, Approximate shock, or heart fellure. List only one cause on each line. interval Between **IMMEDIATE CAUSE (Final** Onset and Death disesse or condition resulting in deeth) DUE TO (OR AS A DO) SEQUENCE OF) arrest OPD CERTIFICATION Sequentially list conditions, DUE TO (OR AS A CONSEQUENCE OF): if any, leeding to immediate cause. Enter UNDERLYING Empermu Mummula CAUSE (Diseese or injury injury, or other DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART if. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 24a. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS MEDICAL COMPLETION OF CAUSE 1 YES 2 NO OF DEATH? 1 YES 2 NO PHYSICIAN: 25. WAS CASE REFERRED TO MEDICAL 28. PLACE OF DEATH (Check only one) OTHER: 1 YES 2 NO 1 | Unpatient 2 | ER/Outpatient 3 | DOA ig Home 5 - Residence 8 - Other (Specify) 27. MANNER OF DEATH 26e. DATE OF INJURY 28b. TIME OF 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED 1 Neturel 5 Pending м 1 YES 2 NO BY 2 Accident Investigation 28e. PLACE OF INJURY — At home, ferm, street, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 28 is 6 Could not be COMPLETED 4 Homicide If Item 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner as stated. 2 MEDICAL EXAMINER: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(e) end menner as steted. 29b. SIGNATURE AND TITLE OF CERTIFIER 29d, DATE SIGNED (Month, Day, Year) 29c. LICENSE NUMBER BE MM MI W331 /2 190 12 0 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Imald M MO ann 32. REGISTRAR'S SIGNATURE 31. DATE FILED (Month, Day, Year) DEC 0 3 '90 lie Davidson-Randall

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

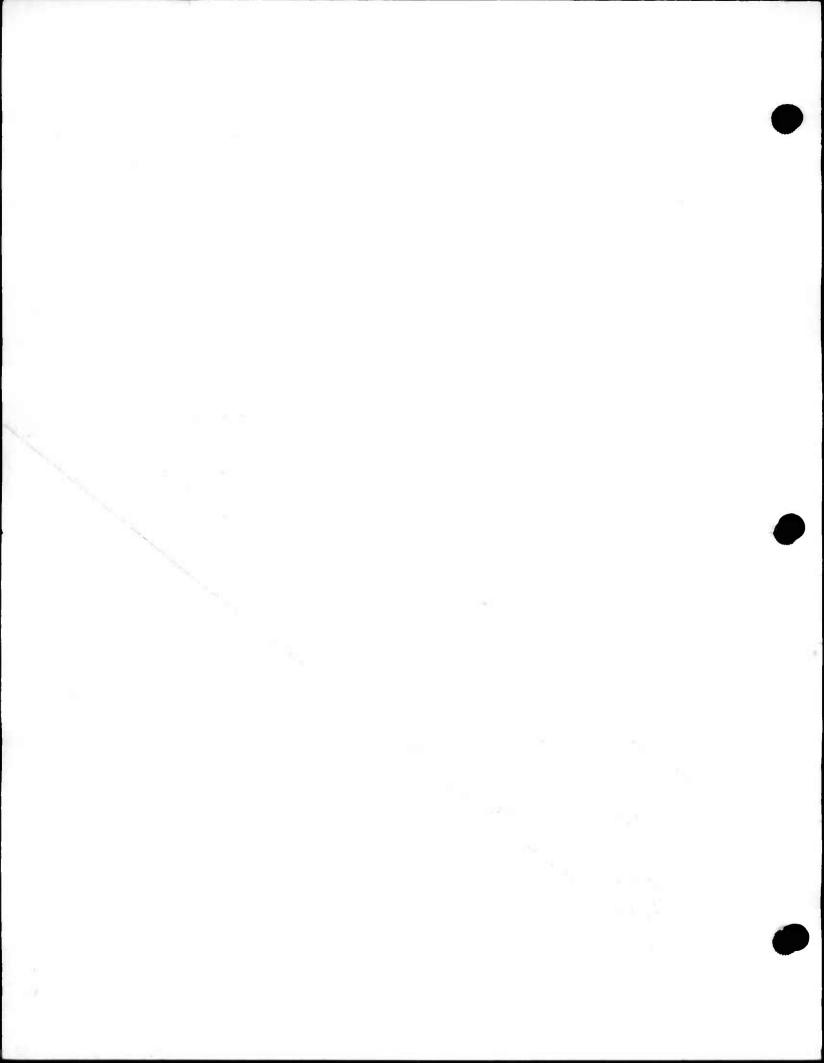
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| | FOR STATE REGISTRAR | STATE OF MARYLA | | TMENT OF H | | MENTAL HYGIENE | 9 | 0 34479 | | |
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| | 1, OECEOENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DAY | YEAR | 3. TIME OF DEATH | | |
| İ | MILTON | ROBERTS | | | | | 23, 199 | | | |
| | | | yrs. lest birthday) | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | 8. BIR | THPLACE (State or Foreign intry) | | |
| | 222-05-8986 . 1 | ØM2□F 71 | YRS. | MONTHS UNTS | HOURS WIN. | 12/26/18 | | ryland | | |
| | 9e. FACILITY NAME (If not institution, give street | and number | | 9b. CITY, TOWN O | R LOCATION OF DE | DEATH 9c. COUNTY OF DEATH | | | | |
| DIRECTOR | VA Hospital - Loch F | Raven | nore | | Baltir | nore | | | | |
| E I | 10a, STATE 10b. COUNTY | | 10c. CITY | r, TOWN OR LOCAT | ON | 10d. INSIOE CIT LIMITS? | | | | |
| E | Maryland WICO | MICO | SA | LISBURY | / | 1 🗌 YES | | | | |
| | 10a. STREET AND NUMBER | | | 101. | ZIP CODE | 10g. CITIZEN OF WHAT COUNTRY? | | | | |
| BY FUNERAL | Route #2, Box 8, Wes | | | | 21801 | | US | SA | | |
| ا يَ | 11. MARITAL STATUS 1 Never Merried 2 Married | P. WAS DECEDENT EVER IN C FORCES? 1 YES IF YES, GIVE WAR OR DAT | J.S. ARMEO 2 NO | If yee, spe | cify_Cuban, Mexican | IC ORIGIN? (Specify Yea n, Puerto Ricen, etc.) | or No — 14. RA Bi | CE — Americen Indian, ack, White, etc. | | |
| ≥ | 3 Widowed 4 Divorced | IF YES, GIVE WAR OR DAT | ES | 1 TES | 2 NO Specify | | | cican American | | |
| | 15. OECEDENT'S EDUCAT | | 16a. DECEDENT'S | USUAL OCCUPATIO | N | 16b. KIND OF BUS | | | | |
| | (Specify only highest grade cor Elementary/Secondery (0-12) | opleted) College (1-4 or 5 +) | (Give kind of v | vork done during mo: e retired.) | t of working | | | | | |
| <u> </u> | 12th | - ' | retired S | Staff Ser | geant | US Airfo | orce | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | | | | | ME (First, Middle, Meiden S | | | | |
| BE | Norris Roberts | | | | Pearl D | utton | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS (Street a | nd Number or Rural F | Route Number, City or Town | n, State, Zip Code) | | | |
| - | Agnes V. Roberts | | | The second secon | | <u>ad, Salisbur</u> | | | | |
| | 200 METHOD OF DISPOSITION 10 Burlel 2 Cremation 3 Remove | I from State | other place) | SITION (Name of cen | | | CATION — City or | | | |
| | 4 Ognation 5 Other (Specify) | |) Vetera | n's Ceme | tery | Bei | ılah, Ma | ryland | | |
| | LATTE A | Dalla. | D O 2 | CILITY Jolley M | emorial | Chapel | | | | |
| | Laura DI | Joney | | Rt. #2 | , Box 920 |), Jersey R | d., Salis | bury, Ma | | |
| ĺ | 23. PART I. Enter the diseases, or con shock, or heart failure. Lis | | | ot antar tha mo | de of dying, auci | h aa cardlac or reapli | retory arreat, | Approximata Interval Batween | | |
| | IMMEDIATE CAUSE (Final | 6 | | | | | | Onaat and Death | | |
| | disease or condition reaulting in death) | Preun | nonia | | | | | luk | | |
| | | DUE TO (OR AS A | | , | | (? | | | | |
| NO. | Sequantially list conditions, b. | DUE TO (OR AS A | | Chen Chr | | | | | | |
| ¥ | if any, leading to immediata cause. Enter UNDERLYING | | | | | | | | | |
| Ħ | CAUSE (Diseasa or Injury that initiated evants | DUE TO (OR AS A | CONSEQUENCE OF | F): | | | | | | |
| CERTIFICATION | reaulting in death) LAST | | | | | | | | | |
| | PART II. Other algorificant conditions of | contributing to death bu | t not regulting | In the underlying | cause given in | Part I. 24e. WAS AN | AUTOPSY | 24b. WERE AUTOPSY FINDINGS | | |
| CAL | | Dehyd | _ | | | PERFOR | MEO? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | | Torique. | LOW LAND | . | | 1 TES 2 | ANO | OF DEATH? | | |
| Σ | | | | | | — I | | 10 123 2 | | |
| PHYSICIAN: MEDIC | 25. WAS CASE REFERRED TO MEDICAL | | | 26. PL | ACE OF OEATH (Ch | eck only one) | | | | |
| Sic | | IOSPITAL: Onpetient 2 - ER/Outpe | tient 3 🗆 DOA | OTHER: 4 Nursing Hom | e 5 🗆 Reeldence | 6 Other (Specify) | | | | |
| Ť | 27. MANNER OF DEATH | 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIM | | URY AT | 28d. DEŞCRIBE HOW II | NJURY OCCURED | | | |
| ВУ Р | 1 Natural 5 Pending 2 Accident Investigation | (1101111) 200, 1000 | | M 1 🗆 | | | | | | |
| | 3 Suicide 6 Could not be | 28a. PLACE OF INJURY - building, etc. (Specia | — Al home, farm, | streel, factory, offic | | 26f. LOCATION (Street a City or Town, State) | and Number or Rui | al Route Number, | | |
| | 4 Homicide determined | H05011 | al | | | | | | | |
| PL | Crieck Orly | N: To the best of my knowle | dge, death occurr | ed at the time, deta | end pieca, end due | to the ceuse(e) and men | mer ea stated, | | | |
| COMPLETED | one) 2 MEDICAL EXAMINER: | On the basis of examination | end/or investigation | on, in my opinion, d | eath occured at the | lime, date end place, en | d due to the ceur | se(e) and manner se stated. | | |
| BE C | 296. SIGNATURE AND TITLE OF CERTIFIER | 0 4 | | | 29c. LICENSE NUI | MBER | 29d. DATE SIGN | IED (Month, Day, Year) | | |
| TO B | Mux Me | Us MD | | | NRO4 | 42 | 111 | 23/90 | | |
| - | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE OF DEA | TH (ITEM 27) (Type | , Print) | | | | | | |
| , | 31. DATE FILED (Month, Day, Year) | Jalls 1 32. REGISTRAR'S SIGNA | TURE | | | | | | | |
| 6 | NOV 2 8 40 | Sulia Davidson | | | | | | | | |
| _ | 1.11.024 50 | The work harden | a- Marsharthy | | | | | | | |



| | 2, 3 shq 6ld | 4 |
|---|--|--|
| | , 2, 3 | |
| | ages 1 | |
| | mit. P | |
| | it pen | |
| ician. | Il-trans | |
| phys. | punia 9 | |
| ending | as the | |
| or att | r use | |
| spital | hed fo | - 2 |
| the ho | detac | ouce |
| od by | od bi | at pa |
| retaine | 5 shor | notifie |
| ay be | page | be 1 |
| E 6 m | ector, | must |
| Pag. | iral dir | iner |
| r death | e fune | ехап |
| PHYSICIAN; The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician | this certificate has been signed by the aftending physician and completely filled in by the | dical |
| 4 hou | filled in | e me |
| ithin 2 | letely a | nt, th |
| w patr | comp | c eve |
| exec | in and | umati |
| ate be | hysicia | r tra |
| certific | ling pl | othe |
| death | aftend | ٦, ٥٠ |
| t the | by the | ılılı |
| es tha | gned | s any |
| requir | een si | show |
| Ne law | has b | n 23 |
| T. IN | ificate | r iter |
| 17SICI | is cert | ed, o |
| ING PH | onth w | mark |
| TEND | TOR: A | 28 Is |
| TO THE HOSPITAL OR ATTENDING PI | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 | IMPORTANT: If Item 28 Is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| PITAL | ERAL | 1 1 1 |
| 8 | 3 | A N |
| I | H : | 5 2 |

| | FOR 1 - STATE REGISTRAR | STATE OF MARYL | | MENT OF H | | MENTAL HYGIENI | Ē | 0 04400 | |
|---------------|--|--|--|---|--------------------------------|--|---------------------------------------|--|--|
| 15 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. DATE OF DEATH MONTH DAY | | 3. TIME OF DEATH | |
| | | Illie Ry | an | | | (1 2 | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX 6. AGE (| and second to the | IF UNDER 1 YEAR HONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF BIRTH (Month, Day, Year) | RTHPLACE (State or Foreign ountry) | | |
| | 264-37-8173 | | | 6 | | 08/18/0 | anama | | |
| O.B. | Anne Arundel Medical Center Anne Arundel Medical Center Anne Arundel Medical Center | | | | | | | | |
| 2 | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY | , | 10c, CITY. | ION | | | 10d. INSIDE CITY | | |
| DIRECTOR | Maryland Ann | e Arundel | | napoli | | | | LIMITS? 1 YES 2 NO | |
| ادّ | 10e, STREET AND NUMBER | e winner | All | | . ZIP CODE | | 10g. CITIZEN (| OF WHAT COUNTRY? | |
| ER/ | 1027 Mastline | Drive | | | | Panai | m a | | |
| FUNERAL | 11. MARITAL STATUS | 12. WAS DECEDENT EVER IF | | 13. WAS DEC | 21401 ENDENT OF HISPAN | IIC ORIGIN? (Specify Yes | | RACE — American Indian, Black, Whits, etc. | |
| BY F | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 YES IF YES, GIVE WAR OR D. | | 1 TYES | 2 NO Specify | n, Puerto Ricen, stc.) | | Specify: hite | |
| | 15. DECEDENT'S EDUC | CATION | 16a. DECEDENT'S U | SUAL OCCUPATION |)M | 16b, KIND OF BUS | · · · · · · · · · · · · · · · · · · · | | |
| COMPLETED | (Specify only highest grade | completed) | (Give kind of wo | rk done during mo retired.) | st of working | 100.1010 01 200 | | | |
| 2 | Elementary/Secondary (0-12) | College (1-4 or 5+) | Tea | cher | | Privat | e Sch | [00 | |
| No. | 17. FATHER'S NAME (First, Middle, Lest) | | 200 | Onci | 16. MOTHER'S NA | ME (First, Middle, Maiden | | 001 | |
| S | | Re | eves | | D. | Ju | stavi | no | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | | | ADDRESS (Street a | | Route Number, City or Town | | | |
| 2 | David C. Rvan. | Jr. | 1027 | Mastl | ine Dri | ive, Anna | polis | MD 21401 | |
| | 20s. METHOO OF DISPOSITION 1 Duriel 2 Cremetion 3 Remo | oval from State | o. PLACE OF DISPOSE other place) | TION (Name of cer | netery, cremetory or | 20c. LO | CATION — City of | or Town, Stata | |
| | 4 Donstion 5 Other (Specify) | 1 | letropol | | | | xandr | ia. VA | |
| | 21. SIGNATURE OR FUNERIAL SERVICE LIC | These / | | Tayl | OR Fund | cium eral Chap | آم | 21401 | |
| | * Kobuy A | Jaylos | | | | ster St., | | | |
| | 23. PART i. Enter the diseases, or o | | | | | | | Approximata | |
| | ahock, or heart feilure. List only one cause on each line. IMMEDIATE CAUSE (Fine) disease or condition resulting in death) a. Electature with employee and Death | | | | | | | | |
| | , | DUE TO (OR AS | CONSEQUENCE OF | : | | | | | |
| N N | Sequentially list conditions, | b. DUE TO (OR AL | CONSEQUENCE OF | | - W | - 9 | | | |
| AŢĬ | if sny, lasding to immediata cause. Entar UNDERLYING | EL AAN I | CONSEQUENCE OF | AN | wedle | USIA | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events | DUE TO OR AS | A CONSEQUENCE OF | | | -4-60 | | | |
| E | resulting in dasth) LAST | , | | | | | | | |
| S | | u. | | | | T T T T T T T T T T T T T T T T T T T | | | |
| CAL | PART ii. Other significant condition | | out not resulting in | tha undarlyin | g cause given in | Part i. 24s. WAS AN PERFOR | | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO | |
| 20 | _ Ching 20 | HUASIS. | | | | 1 _ YES 2 | □ NO | COMPLETION OF CAUSE OF DEATH? | |
| MEDI | | | | | | _ | | 1 TYES 2 NO | |
| PHYSICIAN: | | | | | | | | | |
| 2 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | 26. PI OTHER: | LACE OF DEATH (C) | neck only one) | | | |
| ΙΥS | 1 VES 2 NO | 1 Inpatient 2 ER/Out | | | | 6 Other (Specify) | u servi occime | 20 | |
| | 1 Natural 5 Pending | 28a. DATE OF INJURY (Morith, Day, Year) | 28b. TIME | JRY WO | IURY AT DRK? YES 2 NO | 28d. DEŞCRIBE HOW I | NJUHT OCCURE | | |
| ВУ | 2 Accident Investigation 3 Suicide 5 Could not be | 28e. PLACE OF INJURY | Y — At home, farm, at | | | 281. LOCATION (Street a | and Number or R | ural Route Number. | |
| COMPLETED | 4 Homicide 6 Could not be | building, etc. (Spe | cify) | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | City or Town, State) | | | |
| Щ | 298. CERTIFIER | ICIAN: To the best of my know | whether death occurre | d at the time date | and place, and du | to the sauce/s) and may | mar an stated | | |
| MP | one) | ER: On the basis of axamination | | | | | | use(s) and manner as stated. | |
| | 29b. SIGNATUR AND TITLE OF CERTIFIE | | | | 29c, LICENSE NU | | | INED (Month, Day, Year) | |
| BE | 194.68 | MMHAAA | M | | N m 1 | 2317 | ≥ 1 | 111/02 | |
| 2 | 30. NAME AND ADDIESS OF PERSON WH | O COMPLETED CAUSE OF D | EATH (ITEM 27) (Type, | Print) | 130 | | | 120 110 | |
| | 4801890 C. | JAMAR | ns ml | 1 205 | Ridg | dy Dr | M R | non spals, my | |
| | " NUV 28 1990 Ju | ha Javidoon Kal | THE STATE OF THE S | | V | | | 100 | |

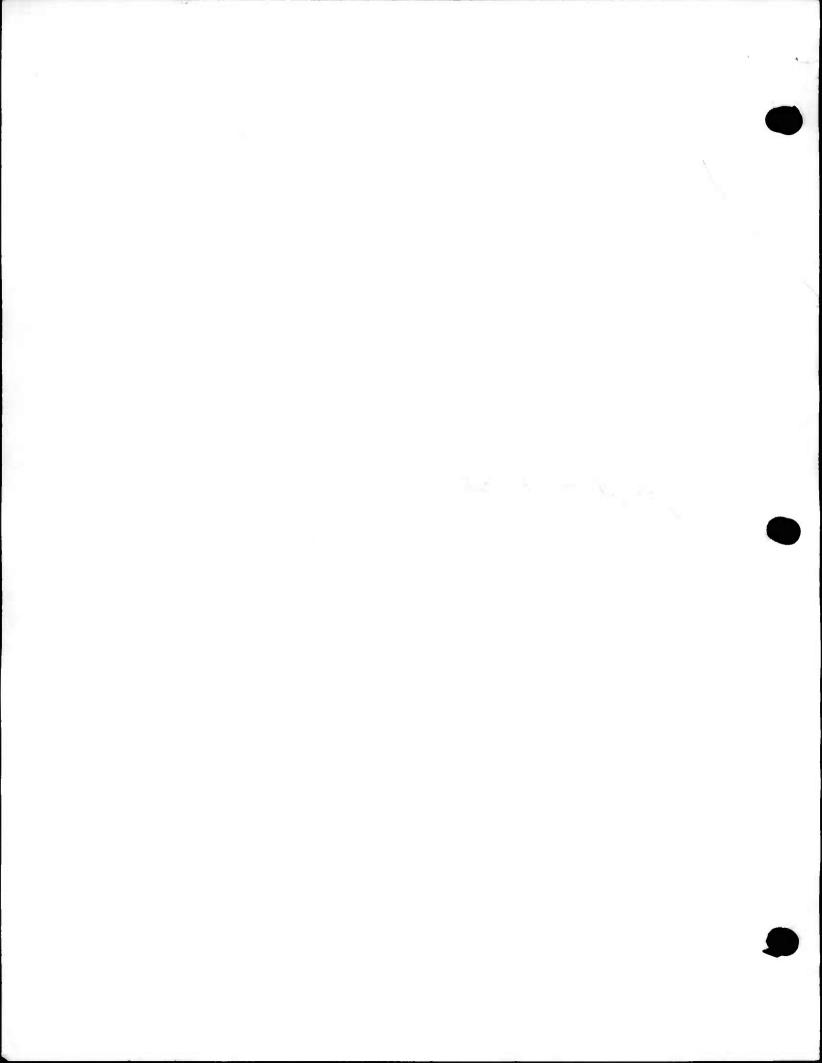
c • At the water of page 17

TO BE COMPLETED BY FUNERAL DIRECTOR

| TO BE COME | OF COMPLETED BY BUYSICIAN, MEDICAL CEDTIFICATION |
|---|--|
| examiner must be notified at once. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |
| al. | be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. |
| ne funeral director, page 5 should be detache | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached |
| r death. Page 6 may be retained by the hosp | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mours after death. Page 6 may be retained by the hosp |

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

| 1 - STATE REGISTRAR | STATE OF MARYLAND A | | | HEALTH AND I | MENTAL HYGIEN REG. NO. | E 5 | 10 34481 | | |
|--|---|---|-----------------------------------|-------------------------|--|---------------|---|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last) | lvina Kozlo | wska | Rader | • | 2. DATE OF DEATH DATE OF DAT | Y YE | | | |
| | SEX 6. AGE (In yrs. Ia | | IF UNDER 1 YEAR | | 7. DATE OF BIRTH (Month, Day, Year) | 8. B | IRTHPLACE (State or Foreign | | |
| 210-03-0013 | OM 2 DF 86 | YRS. | | | 3/3/04 | | sšissippi | | |
| 96. FACILITY NAME (If not institution, give street | 2000 | | | OR LOCATION OF DE | ATH | 9c. COUNTY | 3, 15, 11 | | |
| Rt.1 Box 29 Sout | hview Road | | Newbu | ırg | | Char | les | | |
| 10e. STATE 10b. COUNTY | | 10c. CITY, | TOWN OR LOC | CATION | | | 10d. INSIDE CITY LIMITS? | | |
| Maryland Charl | es | Ne | ewburg | 3 | | | 1 TYES 2 NO | | |
| 10e. STREET AND NUMBER | | | T | 10f. ZIP CODE | | 10g. CITIZEN | OF WHAT COUNTRY? | | |
| Rt. 1 Box 29 Sou | ıthview Road | | | 2066 | 4 | U. | S. A. | | |
| 11. MARITAL STATUS 1 Never Married 2 Married 1 Never Married 4 X Divorced 1 Never Married 4 X Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 Yes 2 NO If yes, specify Cuben, Maxican, Puerto Rican, atc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.) 14. RACE — American Indian, Black, Whita, stc. 15. Was DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuben, Maxican, Puerto Rican, atc.) 16. RACE — American Indian, Black, Whita, stc. 17. Specify: | | | | | | | | | |
| | | | | | | | White | | |
| 15. DECEDENT'S EDUCATI (Specify only highest grade con | npieted) ((| ECEDENT'S L Give kind of wo e. Do NOT use | JSUAL OCCUPA ork done during : | TION most of working | 18b. KIND OF BU | SINESS/INDUST | RY | | |
| Elementary/Secondary (0-12) C | college (1-4 or 5+) | me Ma | | | Λ+ U | 0 m0 | | | |
| 17. FATHER'S NAME (First, Middle, Last) | Ino | me ma | aker | 18. MOTHER'S NA | ME (First, Middle, Maiden | | | | |
| Adam Kozlowska | | | | 11102 (100.00) | ica Mans | | | | |
| 19a. INFORMANT'S NAME (Type/Print) | 1 | 96. MAILING | ADDRESS (Stree | | Route Number, City or Tow | | (e) | | |
| Andrew H. Rader | R | t. 1 | Box | 28. New | burg, Ma | rvland | 1 20664 | | |
| 20a. METHOD OF DISPOSITION 1 X Burlal 2 Cremation 3 Removal | from State 20b. PLACE | E OF DISPOSI | | cemetery, crematory or | | CATION — City | | | |
| 4 Donation 5 Other (Specify) | Holy | | st Ch | .Cemeter | ry Iss | ue, M | aryland | | |
| 21. BIGHATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY | | | | | | | | | |
| Arehart Funeral Home, Inc. La Plata, Maryland 20646-0567 | | | | | | | | | |
| 23. PART I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, auch as cardiec or reepiretory erreet, shock, or heart failure. List only one cause on each line. Approximate Interval Between | | | | | | | | | |
| iMMEDIATE CAUSE (Final disease or condition resulting in death) | Arta:occl | ustic | Cor | Liovasen) | 4 Diseo | ife | Onset and Death | | |
| | DUE TO (OR AS A CONSI | EQUENCE OF |): | | | | ' ' | | |
| Sequentially list conditions, b | DUE TO (OR AS A CONSI | EQUENCE OF |): | | | | <u> </u> | | |
| if any, leading to immediate cause. Enter UNDERLYING | | 750.500 | | | | | | | |
| CAUSE (Disease or Injury that initiated events | DUE TO (OR AS A CONSI | EOUENCE OF |): | | | | | | |
| resulting in deeth) LAST | | | | | | | | | |
| PART II. Other significant conditions of | portributing to death but not | regulting is | n the underly | dna causa alvan In | Pert I. 24s, WAS AF | AUTOBEV | 24b. WERE AUTOPSY FINDINGS | | |
| TAIL III CHICA SIGNICAN CONTINUES | billibuting to deeth but not | racording in | ir tira dilidariy | mig cause given in | PERFO | RMED? | AVAILABLE PRIOR TO COMPLETION OF CAUSE | | |
| | | | | | 1 🗀 YES | 2 THO | OF DEATH? | | |
| | | | | | — I | | 1 TYES 2 NO | | |
| 25. WAS CASE REFERRED TO MEDICAL | | | 26 | PLACE OF DEATH (C) | neck only one! | | | | |
| | OSPITAL: | 3 P DOA | OTHER: | Iome 5 - Residence | | | | | |
| 27. MANNER OF DEATH | 28s. DATE OF INJURY | 28b. TIME | E OF 28c. | INJURY AT | 28d. DESCRIBE HOW | INJURY OCCUR | ED | | |
| 1 Netural 5 Pending | (Month, Day, Year) | INJU | | WORK? YES 2 NO | | | | | |
| 2 Accident Investigation 3 Suicide 8 Could not be 4 Homicide detarmined | 28a. PLACE OF INJURY — At 1 building, atc. (Specify) | home, farm, a | treet, factory, o | ffica | 28f. LOCATION (Street City or Town, State | | Bural Route Number, | | |
| 29a. CERTIFIER | | | | | | | | | |
| (Check only | N: To the bast of my knowledge, on the basis of examination end/o | | | | | | use(a) and manner as stated. | | |
| 29b. SIGNATURE AND TITLE OF CERTIFIER | _ \ N | | | 29c. LICENSE NU | MBER | 29d. DATE SI | GNED (Month, Day, Year) | | |
| HUMBER Chas | o Bypny Int | | | 0273 | 48 | 12 | 13/90 | | |
| 30, NAME AND ADDRESS OF PERSON WHO C | OR MORGONS P | FEN 27) (Type, | Print) | a frata | M 20 | 646 | | | |
| DEC 5 SU Year) | 32. REGISTRAR'S SIGNATURE | latte | , | | | | | | |



3. TIME OF DEATH

10d. INSIDE CITY 1 YES 2 NO

14. RACE — American Indian, Black, White, etc.

20604-0156

Approximate Interval Batween

24b. WERE AUTOPSY FINDINGS AMAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?

1 TES 2 NO

Onset and Daeth

10:37 6. BIRTHPLACE (State or Foreign Country) Pennsylvania

injury, or other traumatic event, the medical examiner must be notified at once,

shows any

item 23

marked, or

IMPORTANT: It Item 28 is BE COMPLETED

23

BY

2

| | 1 - STATE REGISTRAR | STATE OF I | MARYL | | | TMENT ICATE | | | | | HYGIEN REG. NO. | Ε . | | 0.4 |
|----------------------------------|--|---|-----------|------------------------|-----------------------|-------------------------------|--------------------------------------|-------------------|-----------|------------------------------|------------------------|---------------------------------------|---------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | 2. DATE OF | - | | EAR | 3. TIME OF DEA |
| | JAMES | R | OBER | T | | R | OON | EY | | DEC | | | | 10:37 |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | | In yrs. last | birthday) | IF UNDER | | IF UNDER | | 7. DATE OF | TE OF BIRTH 6. BIRTHPL | | | PLACE (State or F |
| | 180-30-3644 | 1 🛛 M 2 🗌 F | 52 | - | YRS. | MONTHS | DAYS | HOURS | MIN. | 8 4 1 6 1 1 1 9 3 8 | | | ² er | nsylva |
| | 9a, FACILITY NAME (If not institution, give s | treet and number) | | | | 9b. CITY | TOWN C | R LOCATI | ON OF DE | ATH | | 9c. COUNTY | OF DI | EATH |
| E I | PHYSICIANS MEMO | RTAL H | OSPI | TAI. | | I | A P | I.AT | Α | | | CHAI | RI.F | S |
| DIRE | Maryland Cha | | | | | | OIT | | | | | 10d. INSIDE CIT LIMITS? 1 YES 2 | | |
| FUNERAL DIRECTOR | 100. STREET AND NUMBER 1004 Dartmouth Road | | | | | | 101. ZIP CODE 10g. CITIZEN OF WI USA | | | | | | | 'HAT COUNTRY? |
| B | 11. MARITAL STATUS 1 □ Never Merried 2 □ Merried 3 □ Widowed 4 □ Divorced 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ├── YES 2 □ NO IF YES, GIVE WAR OR DATES VIETNAM | | | | | | li yes, sp | | n, Mexica | IIC ORIGIN? n, Puerto Ric | | - 1 | RACE Black Specific | - American Inc , Whita, etc. fy: . te |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | CATION completed) College (1-4 or 5 | +) | (GN | e kind of Do NOT u | USUAL Owork done se retired.) | during mo | ON at of world | ng | | | SINESS/INDUS | | |
| M M | 12 | | | Ма | ste | r Sg | įį. | | | | | USAF | | |
| 8 | 17. FATHER'S NAME (First, Middle, Last) | | | | | | | | | ME (First, Mic | | | | |
| H | John Rooney | | | | | | √an (| | | | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | | | | | | n, State, Zlp Co | | 00.400 |
| | Barbara A. Rooney 1004 Dartmouth Rd., Waldorf, Md. 200 | | | | | | | | | | | | | |
| | 4 Donation 5 Dother (Specify) | □ Cremetion 3 □ Removal Irom State s □ Other (Specify) Maryland Veterans Cemetery Cheltenham | | | | | | | | | | | | |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156. Waldorf. Md. 2 | | | | | | | | | . 2060 | | | | |
| | 23. PART I. Enter the disease or shock, or heart failure. IMMEDIATE CAUSE (Final disease or condition resulting in death) | Liat only one ca | use on a | ach Ilna. | | not antar | the mo | da of dy | ing, suc | h as cerdia | ic or resp | Iratory arres | | Approxir Interval Onset as |
| | resulting in daalin) | B. RES | (OR AS A | CONSEC | UENCE O |)F): | 10 | | 10 | | 63 ann | <u> </u> | | |
| ATIO | if any, leading to immediate cause. Enter UNDERLYING | DUE TO | OR AS | CONSEO | UENCE O | F): | <i>y</i> (4 | | 29 1 | | | | | |
| SERTIFIC | CAUSE (Disease or Injury that Initiated events resulting in death) LAST | d. | OR AS A | CONSEC | UENCE O | F): | | | | | | | | |
| PHYSICIAN: MEDICAL CERTIFICATION | PART II. Other significant condition | ns contributing t | o death b | out not ra | sulting | In tha u | ndariyin | g cause | given in | | PERFO | RMED? | 24b | WERE AUTOPSY AMAILABLE PRIO COMPLETION OF OF DEATH? 1 YES 2 |
| ä | | | | | | | | | | | | | | |
| ICIA | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | 1 | OTHE | R: | | 1070 | eck only one, | | | | |
| PHYS | 1 VES 2 NO 27. MANNER OF DEATH | 1 Inpatient 2 28e, DATE 0 (Month, | | patlant 3 _y | 26b. TII | | 28c. IN. | JURY AT | lesidenca | 6 Other | | INJURY OCCU | RED | |

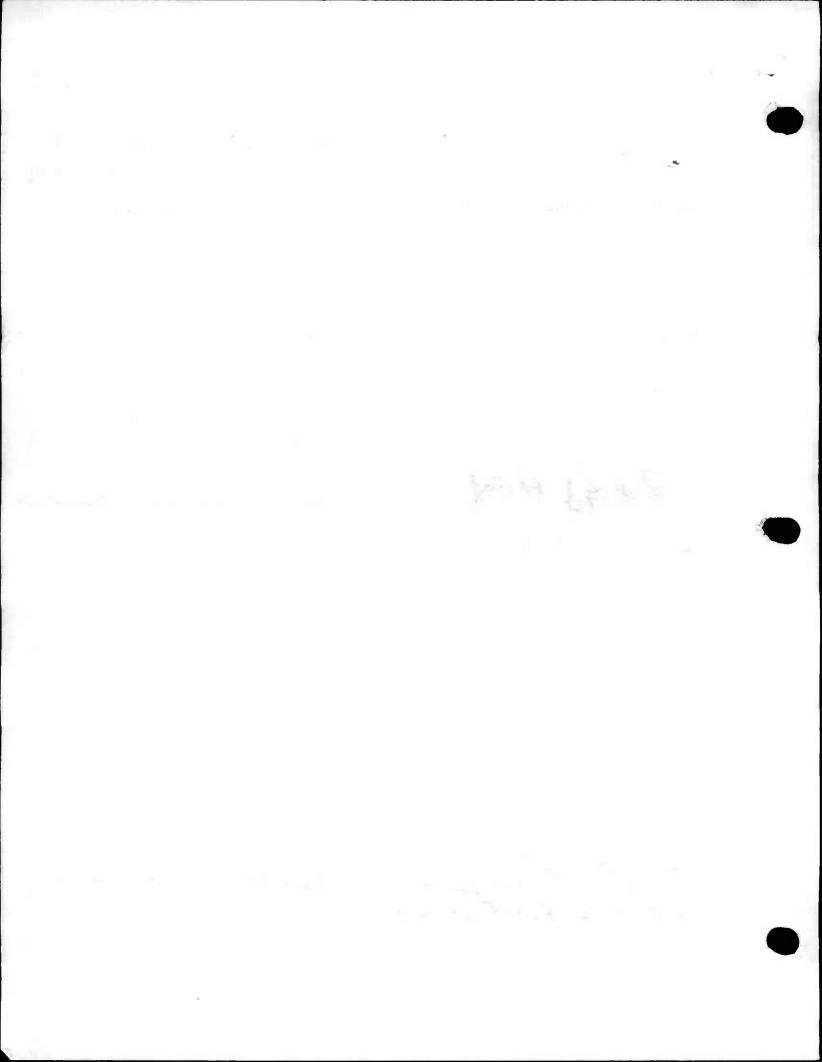
HOSPITAL: OTHER: 1 YES 2 NO 1 | Inpatient 2 | ER/Outpatient 3 | DOA ne 5 🗆 Residence 6 🗆 Other (Specify) 28e. DATE OF INJURY (Month, Day, Year) 27. MANNER OF DEATH 28d. DESCRIBE HOW INJURY OCCURED 26b. TIME OF INJURY 26c, INJURY AT WORK? Natural 5 Pending Investigation 1 YES 2 NO 2 Accident 28s. PLACE OF INJURY — At home, farm, etreet, factory, office building, etc. (Specify) 3 Suicide 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 4 Homicide

29a. CERTIFIER (Check only one) 1 CERTIFYINO PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as atsted.

296. SIGNATURE AND THILE OF CERTIF 29c. LICENSE NUMBER 29d, DATE SIGNED (Month, 679 0

DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year DEC 0 5 '9 32. REGISTRAR'S SIGNATURE Julia Davidson-Randelle



BALTIMORE, MARYLAND 21203-3146

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24

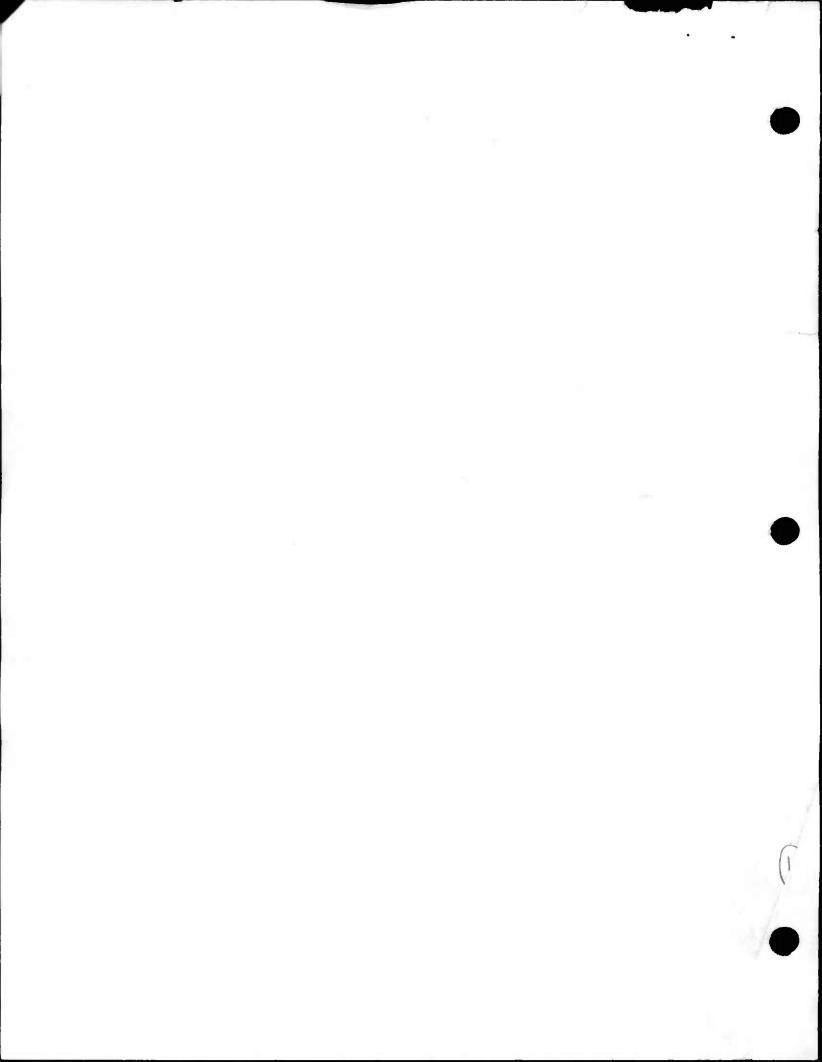
DIVISION OF VITAL RECORDS, P.O. BOX 13146,

| | 1 - STATE REGISTRAR | STATE OF MARYI | AND / DEPAR Certif | | | | | | HYGIENE REG. NO. | | | |
|--------------------|--|--|----------------------------------|---|-------------|-------------------------|-----------|-------------------------|-------------------------------|--|--------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | OLITA I | 10/11/2 | 0 | DEA | | 2. OATE OF | | | YEAR : | 3. TIME OF DEATH |
| | 4. SOCIAL SECURITY NUMBER | Louise | (In yrs. lest birthday) | / | 05 | 5 | | Noven | | 7.19 | 90 | FEM M |
| | 219-36-7234 | 1 M 2 M | 97 YRS. | IF UNDER | DAYS | HOURS | MIN. | 7. DATE OF (Month, D | | 8. BIRTHPLACE (State or Foreign Country) | | |
| | 9a. FACILITY NAME (If not institution, give s | treet and number) | • / | 9b. CITY | , TOWN C | R LOCATIO | ON OF DE | | 1-101. | 9c. COUNT | Y OF DE | ATH |
| OR | PENINSULA GENERAL | HOSPITAL | | S. | ALIS | BURY | , MD |) | | WICC | MICO | |
| DIRECTOR | RESIDENCE OF DECEDENT 10a, STATE 10b, COUNT | Y | 10c. CIT | ITY, TOWN OR LOCATION | | | | | | | 1 | Od. INSIDE CITY |
| 5 | Maryland Worce | ster | Pod | como | ke | | | 1 🛭 | | | LIMITS? | |
| RAL | 10e. STREET AND NUMBER | | | 10f. ZIP CODE | | | | | 10g. CITIZEN OF WHAT COUN | | | AT COUNTRY? |
| FUNERAL | 415 Market Str | 12. WAS DECEDENT EVER | IN U.S. ARMED | 21851 13. WAS DECENDENT OF HISPANIC ORIGIN? (S) | | | | | Specify Vea c | | SA A BACE - | - American Indian |
| BY | 1 Never Married 2 Married 3 Widowed 4 Divorced | FORCES? 1 TYES | 2 XNO | | If yea, sp | | n, Maxica | n, Puarto Rica | | | Black, Specify. | - American Indian, Whita, atc. White |
| 品 | 15. DECEDENT'S EDU (Specify only highest grade | CATION completed) | 16a. DECEDENT'S (Give kind of | work done | | | g | 18b. KI | ND OF BUSI | NESS/INDU | STRY | |
| PE | Elementary/Secondary (0-12) | College (1-4 or 5 +) ∆ | School | | aho | r 0. | Dri | nain | - 1 | | | |
| COMPLETED | 17. FATHER'S NAME (First, Middle, Last) | -1 | DCIIOOI | rea | CITE | _ | | ME (First, Mide | | urname) | | |
| BE C | James Parker R | oss | | | | Cla | ıra | J. Wa | arner | - | | |
| 0 | 19a. INFORMANT'S NAME (Type/Print) | Desir | | | | | | Route Number, | | | |) F] |
| | Leona Madeline 200 METHOD OF DISPOSITION | 20 | b. PLACE OF DISPO | | | | | comol | | ATION C | 218 | |
| | 1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify) | oval from State | John W. | Tay | lor | Men | ı. C | Cem. | | | | ville, Va. |
| | 21. SIGNATURE OF FUNERAL SERVICE LICENSEE 22. NAME AND ADDRESS OF FACILITY Melson Funeral Home | | | | | | | | | | | |
| | Scotts. | Melson | | P | O B | OX 6 | 4, | Pocor | noke, | , Md | . 2] | 1851 |
| | 23. PART I. Entar the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween Onset and Death disease or condition resulting in death) DUE TO (OR AS A CONSCOURAGE OR): | | | | | | | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| CERTIFICATION | Sequentially list conditions, if any, laading to immediate | | | | | | | | | | | |
| ICA | cause. Enter UNDERLYING CAUSE (Disease or injury | a ASCUP | A CONSEQUENCE O | | | | | | | | | |
| RTI | that initiated avents resulting in death) LAST | 4 | A CONSEQUENCE O | · ,. | | | | | | | | |
| | PART II. Other aignificant condition | a contributing to death | but not resulting | In the sa | ada chila | | daram in | Dort I or | la. WAS AN A | | | |
| PHYSICIAN: MEDICAL | | | out not radding | III the or | idattyini | A cause (| jivan in | | PERFORM | ED? | | WERE AUTOPSY FINDINGS WALLABLE PRIDR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| IAN | 25. WAS CASE REFERRED TO MEDICAL | | | | 26. PL | ACE OF O | EATH (Ch | eck only one) | | | | |
| VSIC | EXAMINER? | HOSPITAL: 1 inpatient 2 in ER/Ou | Ipatient 3 🗆 DOA | OTHER 4 I Nur | | 6 5 🗆 Re | sidence | 8 - Other (S | (pecify) | | | |
| ВУ РН | 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28a. DATE OF INJURY (Month, Day, Year) | | ME OF JURY M | | URY AT PRK? YES 2 | NO NO | 28d. DESCR | IBE HOW IN | JURY OCC | URED | |
| | 3 Suicide 6 Could not be 4 Homicide datarmined | 28e. PLACE OF INJUR building, atc. (Sp. | Y — At home, ferm, ecify) | street, fact | tory, offic | • | | 28f. LOCATI City or | ON (Street an Town, State) | d Number o | or Rural Ro | ute Number, |
| COMPLETED | | ICIAN: To the best of my kno | | | | | | | | | | and menner as stated. |
| BEC | 296. SIGNATURE AND TITLE OF CERTIFIE | R | | | | 29c. LICE | | | | 29d. DATE | SIGNED (| Month, Day, Year) |
| 2 | 20 NAME AND ADDRESS OF DEPOSIT | - Way, MD | FATURET OF C | 0.1-** | | W. | 331/ | / | | > / | 1/27 | 1/80 |
| | 30. NAME AND ADDRESS OF PERSON WI | ONACO M | - WOUD | MI) |) | | | | | | | |
| 6 | DEC 03 '90 | A REGISTHAR'S SIG | n-Handell | | | | | | | | | |

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| | | emit. Pages 9 | |
|--|--|---|--|
| BALTIMORE, MARYLAND 21203-3146 | TO THE MOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 mous after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages | be filed within 72 hours after death with the State Dept. of reasith and Mental rygbeine prior to build, definition. IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| 46, | d within 24 no | ompletely filled | be filed within 72 hours after death with the State Dept. of readin and Mental rygiente prior to build, demation, of removal, IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical ex |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | te be execute | sician and co | traumatic |
| P.O. B | eath certifical | ittending phy | , or other |
| ORDS, | that the de | ned by the a | any injury |
| . RECC | law requires | is been sign | 23 shows |
| : VITAI | ICIAN: The | certificate ha | , or item |
| ON OF | IDING PHYS | After this | is marked |
| DIVISI | L OR ATTEN | DIRECTOR | hours after item 28 i |
| | IE HOSPITAL | HE FUNERAL | SETANT: II |
| 1) | 10 1 | 10 | IMPC |

| The Decedent's Boundarion The Decedent of Marking (Specify only highest produc completed) The Decedent of Marking (Specify only highest produc completed) The Domestic Completed of Marking (Specify only highest produc completed) The Domestic Completed of Marking (Specify only highest produc completed) The Domestic Completed of Marking (Specify only highest produc completed) The Domestic Completed of Marking (Specify only highest produc completed) The Domestic Completed of Marking (Specify only highest produc completed on the Domestic Complete Completed on the Domestic Complete | | REGISTRAR | | CERTIF | ICATE | OF | DEATH | REG. NO. | | | |
|--|------------|--|-------------------------|---|--------------------------------------|-------------------|-----------------------|--|---------------|---------------------------------|---|
| THE CLICATE SAME PART AND PARTY AND | į | 1. DECEOENT'S NAME (First, Middle, Last) | | , | | | | MONTH DA | Y | YEAR | . TIME OF DEATH |
| 213-08-3828 1 m x 2 m r 58 | | | | | | November 23, 1990 | | | 12:45P M | | |
| Security made (if not entertion, per size of analogy) NTH C (Incal Center Bethesda, Mary) and Montgomery NTH C (Incal Center Bethesda, Mary) and Montgomery 100 100 100 100 100 100 100 100 100 10 | | | - The second second | | | \rightarrow | | 7. DATE OF BIRTH (Month, Day, Year) NOV . 30 | 1931 | 8. BIRTHPL Country) St. V | incent |
| THE STREET AND NUMBERS 1. 20.78 S | | 9a. FACILITY NAME (If not institution, give st | 9b. CITY, 1 | TOWN O | R LOCATION OF CE | | | NTY OF DEA | тн | | |
| THE STREET AND NUMBERS 1. 20.78 S | TOR | NIH, The Clinical Center | | | | esda | , Maryla | ınd | Montgomery | | |
| THE STREET AND NUMBERS 1. 20.78 S | E I | | | 10c. CIT | Y, TOWN OR | LOCATI | ON | | | 10 | |
| The Secondary Country of the Secondary Country of S | | - / | ontgomery | Нуа | ttsvil | | | | 1 X YES 2 NO | | |
| The Secondary Country of the Secondary Country of S | VERA | 2423 Hannon St. | | | | 2 | 20783 | | | dines | |
| ARTHUR HAVILLION The ANCHORM'S NAME (Fig. Pairs) The ANCHORM'S N | В | 1 Never Married 2 Married | FORCES? 1 TYES | 250NO | 25/XNO If yes, specify Cuban, Maxica | | | n, Puarto Rican, etc.) | or No | | |
| ARTHUR HAVILLION The ANCHORM'S NAME (Fig. Pairs) The ANCHORM'S N | TED | (Specify only highest grade | completed) | (Give kind of | w * done du | | | | | DUSTRY | |
| ARTHUR HAVILLION The ANCHORM'S NAME (Fig. Pairs) The ANCHORM'S N | IPLE | | College (1-4 or 5+) | -6.600 | | RK | | Pri | vate | | |
| ARTHUR HAVILLION The ANCHORM'S NAME (Fig. Pairs) The ANCHORM'S N | S S | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | Surname) | | |
| CORNILLEUS HAMILTON RODERIQUEZ 100. PLACE OF GENERAL PROPERTION 100. PLACE OF GE | | ARTHUR HAMILTON | N . | | | | 'MARY SA | ANDY | | | |
| 20. METRICO OF DISPOSITION 1 Surfax 2 Centerior 3 M semoval from State 2 Semoval School | | 19a. INFORMANT'S NAME (Type/Print) | | 19b. MAILING | ADDRESS | (Street ar | nd Number or Rural F | Route Number, City or Tow | n, State, Zip | Code) | |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PREPORMED? 1 25 NA SCASE REFERENCE TO MEDICAL EXAMINER? 1 1 1 1 1 1 1 1 1 | ۲ | CORNILEUS HAMILTON | N RODERIQUEZ | 914 N | 10TH | ST. | , FT. PI | ERCE FL | 34950 |) | |
| 23. PAST Finiter the diseases, or complications that caused the death. Do not enter the mode of dying, such ex cerdiec or reapiratory arrest, shock, or heart felium. List only one cause on each line. Approximate interval between the cause of the c | | 1 ☐ Burial 2 ☐ Cremation 3 🔀 Rem | oval from State | b. PLACE OF OISPO other place) Mills Fu | sition (Nam neral | HON | netery, crematory or | | | | |
| 23. PAST Finiter the diseases, or complications that caused the death. Do not enter the mode of dying, such ex cerdiec or reapiratory arrest, shock, or heart felium. List only one cause on each line. Approximate interval between the cause of the c | | 21. SIGNATURE OF FUNERAL SERVICE LIC | CENSEE A A | 100 | Ma: 42 | rsha 17 | all's Fur th Stree | neral Home | ashir | ngton, | D.C. |
| PART II. Other aignificant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 24s. Was AN AUTOPSY PERFORMED? 1 Of YES 2 NO 25. WAS CASE REFERREO TO MEDICAL EXAMINER? 1 YES 2 NO 26. PLACE OF DEATH (Check only one) 27. MANNER OF DEATH 1 Netural 5 Pending Investigation 3 Sulcide 8 Could not be detarmined Investigation 3 Sulcide 8 Could not be detarmined Delical Examiner: On the basis of axamination and/or investigation, one) 28s. CERTIFIER (Check only one) 28s. LOCATION (Street and Number or Rural Route Number, Chy or Your, State) 29s. LICENSE NUMBER 29s. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Dey, Near) 30. NAME AND storage as of PERSON WHO COMPLETED CAUSE OF PEATS (Month, Dey, Near) 2000 Rockville Pike, Bethesda, Md. 20892 | TIFICATION | disease or condition resulting in death) e | | | | | | | | | |
| PERFORMED? Description of Cause of Death Description of Cause of Death Description of Cause of Death Description of Cause of Death Description of Cause of Death Description of Cause of Death Description of Cause of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Death Description of Description of Death Description of Death Description of Descri | | | d | | | | | | | | 1 |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation. In my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND EXPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH DEM 27 (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 33. NAME AND (Month, Day, Year) 34. DATE FILED (Month, Day, Year) 35. REGISTRAR'S SIGNATURE 36. COuld not be detarmined 26. PLACE OF INJURY — At home, farm, street, factory, office 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 27. CHY OF ROW, State) 281. LOCATION (Street and Number or Rural Route Number, City or Row, State) 285. LOCATION (Street and Number or Rural Route Number, City or Row, State) 286. LOCATION (Street and Number or Rural Route Number, City or Row, State) 287. LOCATION (Street and Number or Rural Route Number, City or Row, State) 288. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, Cit | : MEDICAL | PART II. Other algoriticant condition | a contributing to deeth | but not reaulting | in the und | deriying | g cause given in | PERFO | RMED? | 0 | WAILABLE PRIOR TO COMPLETION OF CAUSE OF CEATH? |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation. In my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND EXPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH DEM 27 (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 33. NAME AND (Month, Day, Year) 34. DATE FILED (Month, Day, Year) 35. REGISTRAR'S SIGNATURE 36. COuld not be detarmined 26. PLACE OF INJURY — At home, farm, street, factory, office 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 27. CHY OF ROW, State) 281. LOCATION (Street and Number or Rural Route Number, City or Row, State) 285. LOCATION (Street and Number or Rural Route Number, City or Row, State) 286. LOCATION (Street and Number or Rural Route Number, City or Row, State) 287. LOCATION (Street and Number or Rural Route Number, City or Row, State) 288. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, Cit | A | | | | | 26. PL | ACE OF DEATH (Ch | eck only one) | | | |
| 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation. In my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 30. NAME AND EXPRESS OF PERSON WHO COMPLETED CAUSE OF DEATH DEM 27 (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 33. NAME AND (Month, Day, Year) 34. DATE FILED (Month, Day, Year) 35. REGISTRAR'S SIGNATURE 36. COuld not be detarmined 26. PLACE OF INJURY — At home, farm, street, factory, office 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 26. LOCATION (Street and Number or Rural Route Number, City or Row, State) 27. CHY OF ROW, State) 281. LOCATION (Street and Number or Rural Route Number, City or Row, State) 285. LOCATION (Street and Number or Rural Route Number, City or Row, State) 286. LOCATION (Street and Number or Rural Route Number, City or Row, State) 287. LOCATION (Street and Number or Rural Route Number, City or Row, State) 288. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, City or Row, State) 289. LOCATION (Street and Number or Rural Route Number, Cit | Sic | | HOSPITAL: | tpatient 3 DOA | | | e 5 🗆 Residence | 8 Other (Specify) | | | |
| 2 Gooden investigation 3 Suicide 4 Homicide 8 Could not be determined 28e. PLACE OF INJURY — At home, farm, street, factory, office 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. SIGNATURE AND LIDE OF CERTIFIER 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) 30. NAME AND (MORESS OF PERSON WHO COMPLETED CAUSE OF PEATA UPEN 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE 33. DATE FILED (Month, Day, Year) 34. DATE FILED (Month, Day, Year) 35. REGISTRAR'S SIGNATURE 29c. LICENSE NUMBER 29d. OATE SIGNED (Month, Day, Year) 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | | 26a. DATE OF INJURY | 28b. TII | WE OF | 28c. INJI WO | URY AT RK? | | NJURY OC | CUREO | |
| 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. OATE SIGNED (Month, Dey, Vear) 30. NAME AND (Month, Dey, Vear) 31. DATE FILED (Month, Dey, Vear) 32. REGISTRAR'S SIGNATURE | | 2 Accident Investigation 3 Suicide 8 Could not be building, etc. (Specify) | | | | | | | | | ute Number, |
| 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. LICENSE NUMBER 296. OATE SIGNED (Month, Dey, Vear) 30. NAME AND (Month, Dey, Vear) 31. DATE FILED (Month, Dey, Vear) 32. REGISTRAR'S SIGNATURE | MPLET | (Check only | | | | | | | | | |
| 30. NAME AND (PORESS OF PERSON WHO COMPLETED CAUSE OF PEATA DEM 27) (Type, Print) 30. NAME AND (PORESS OF PERSON WHO COMPLETED CAUSE OF PEATA DEM 27) (Type, Print) 31. DATE FILED (Month, Day, Year) 32. REGISTRAN'S SIGNATURE | | | | on and/or investigati | On, In my op | olnion, d | | | | | |
| 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | | KK | m. D1 | 11/ | | | | | 1 | 10 | 6-90 |
| 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE | ۲ | 18 1 1 | O COMPLETED CAUSE OF D | | | ille | Pike, l | Bethesda, | Md. 2 | 20892 | |
| | | 31. DATE FILED (Month, Day, Year) | 0 | NATURE | | | - | | | | |

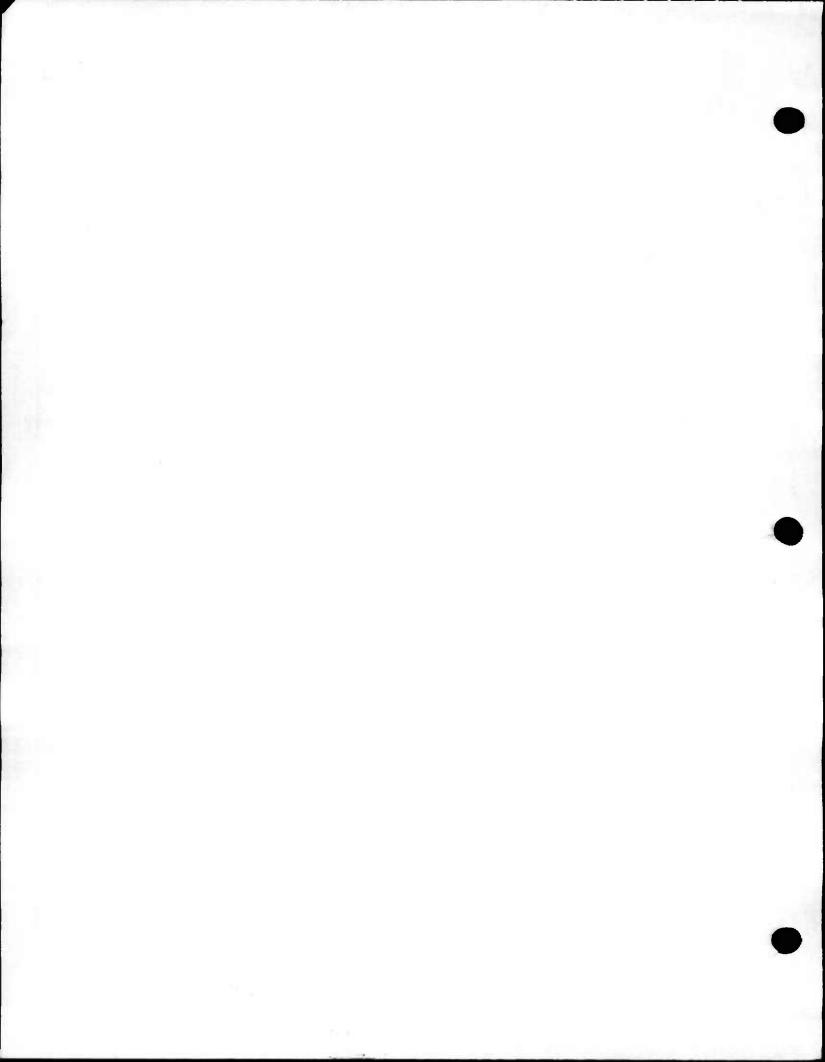


| BALTIMORE, MARYLAND 21203-3146 | cours after death. Page 6 may be retained by the hospital or attending physician. | led in by the funeral director, page 5 should be detached for use as the burial-transit (, or removal. | medical examiner must be notified at once. |
|--|--|--|--|
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within a mount after death. Page 6 may be retained by the hospital or attending physician. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit parties after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once. |

31. DATE FILED (Month, Day, Year)

32. REGISTRAR'S SIGNATURE a Say doon fondall

| | FOR STATE REGISTRAR | STATE OF M | | EPARTMI RTIFICA | | | | ENTAL HYGIEN REG. NO. | E | 20 | 34485 |
|---------------------------------|--|--|--|--|--|----------------------|---------------|--|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | 1 | | | | | 2. DATE OF DEATH DA | | YEAR 3. | TIME OF DEATH |
| - 1 | W. O. k | Eush | ans | | | | | 11 23 | | 90 | 2:30 ant |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. ast bi | - | NDER 1 YEAR | IF UNDER | | 7. DATE OF BIRTH (Month, Day, Year) | 1 | 8. BIRTHPLA Country) | ACE (State or Foreign |
| - | 462-18-5530 | <u>3</u> € M 2 □ F | 680 | YRS. MONT | HS DAYS | HOURS | MIN. | 12-16-2 | 21 | Okla | homa |
| | 9a. FACILITY NAME (If not institution, give atreet and number) | | | | CITY, TOWN | R LOCATI | ON OF DEA | тн | 9c. COUNTY OF DEATH | | |
| DR. | 1720 Swinburn | 1720 Swinburne Avenue | | | | ofto | n | | Anne | e Aru | ndel |
| 5 | RESIDENCE OF DECEDENT | | | | | | | | | | |
| DIRECTOR | | | | | | crofton | | | | | Od. INSIDE CITY LIMITS? YES ZXNO |
| FUNERAL | 10e. STREET AND NUMBER | | | | 101 | ZIP COD | | | 10g. CITIZ | EN OF WHA | AT COUNTRY? |
| ER | 1720 Swinbur | ne Avenu | ıe | | | 2 | 1114 | | | USA | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDENT | EVER IN U.S. ARME | ED | | | | C ORIGIN? (Specify Yes | or No- | 14. RACE - | - American Indien, Vhite, atc. |
| | 1 Never Married 2 Married | IF YES, GIVE W | YES 2 NO | | | | Specify: | Puarto Rican, etc.) | | Specify: | |
| BY | 3 Widowed 4 Divorced | | | l | | | | | | | White |
| COMPLETED | 15. DECEDENT'S EDU (Specify only highest grade Elementary/Secondary (0-12) | | (Give | EDENT'S USUA kind of work of to NOT use reti | AL OCCUPATION fone during model ad.) | ON list of workli | ng | 16b. KIND OF BU | SINESS/INDU | JSTRY | |
| PL | 4 | 2 | | arper | ter | | | N | ASA | | |
| OM | 17. FATHER'S NAME (First, Middle, Last) | | | | | 18. MOT | HER'S NAM | E (First, Middle, Malden | Surname) | | |
| | Weaver Rushi | ng | | | | Or | al M | AcKinney | | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | _ | 19b. I | MAILING AOD | RESS (Street I | | | oute Number, City or Tow | n, State, Zip | Code) | |
| 2 | Donald P. Rus | hing | 15 | 717 A | 11an | wood | Dr. | ,Silver | Spri | ing, | Md.20906 |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremetion 3 Rem | noval from Stata | 20b. PLACE OF other place | 9) | | | | | 20c. LOCATION City or Town, State | | |
| | 4 Donation 5 Other (Specify) | | Md. | State | e Vet | erar | is Ce | em. C | helte | enhar | m,Md. |
| | 21. SIGNATURE OF TRIMERAL SERVICE AS | CENSEE | 1 | | 6633 | 010 | Ale | exander | nera. Ferry | y Roa | ad. |
| - | 23. PART i. Enter the diseases, or | and pilostines that | To do do do do do do do do do do do do do | | | | | 20735 | | | 1. A constitution |
| | 23. FARTI I. Eliter tile diseases, Ol | | | | | | | | | | |
| | shock, or heart failure. | | | th. Do not a | nter the mo | oa or ay | ing, sucn | as cardiac or resp | retory arre | est, | Approximate interval Between |
| | IMMEDIATE CAUSE (Finel | | | th. Do not a | | | | | retory arre | est, | interval Between Onset and Death |
| | | List only one caus | se on aech lina. | | | | | ncer | retory arre | est, | Intarval Between |
| | IMMEDIATE CAUSE (Finel disease or condition | List only one caus | | | | | | | iretory arre | est, | interval Between Onset and Death |
| NC | IMMEDIATE CAUSE (Finel disease or condition resulting in death) | a | se on sech lins. (OR AS A CONSEQU | JENCE OF): | | | | | iretory arre | est, | interval Between Onset and Death |
| VION | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate | a | se on aech lina. | JENCE OF): | | | | | iretory arre | est, | interval Between Onset and Death |
| ICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a. DUE TO (| (OR AS A CONSEQU | IENCE OF): | | | | | retory arre | est, | interval Between Onset and Death |
| TIFICATION | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | a. DUE TO (| se on sech lins. (OR AS A CONSEQU | IENCE OF): | | | | | iretory arre | est, | interval Between Onset and Death |
| ERTIFICATION | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury | a. DUE TO (| (OR AS A CONSEQU | IENCE OF): | | | | | iretory arre | est, | interval Between Onset and Death |
| L CERTIFICATION | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events | B. DUE TO (| (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU | JENCE OF): JENCE OF): | 101 | ng | ca | NCEV | I AUTOPSY | 24b. W | Interval Between Onset and Death |
| 4 | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | B. DUE TO (| (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU | JENCE OF): JENCE OF): | 101 | ng | ca | N CEV | I AUTOPSY PIMED? | 24b. W | Interval Between Onset and Death |
| 4 | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | B. DUE TO (| (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU | JENCE OF): JENCE OF): | 101 | ng | ca | NCEV | I AUTOPSY PIMED? | 24b. W | Interval Between Onset and Death 1/2 Y S. VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 4 | iMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | B. DUE TO (| (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU | JENCE OF): JENCE OF): | 101 | ng | ca | N CEV | I AUTOPSY PIMED? | 24b. W | Interval Between Onset and Death 1/2 Y S. |
| 4 | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST | B. DUE TO (| (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU | JENCE OF): JENCE OF): | a underlyin | Q couse | CQ. | Pert I. 24e. WAS AN PERFO | I AUTOPSY PIMED? | 24b. W | Interval Between Onset and Death 1/2 Y S. VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 4 | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions. | B. DUE TO (DUE | (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU death but not rea | JENCE OF): JENCE OF): JENCE OF): JENCE OF): | a underlyin | Q couse | ca | Pert I. 24e. WAS AN PERFO | I AUTOPSY PIMED? | 24b. W | Interval Between Onset and Death 1/2 Y S. VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
| 4 | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO | B. DUE TO (DUE | GOR AS A CONSEQUE (OR AS A CONSEQUE (OR AS A CONSEQUE (OR AS A CONSEQUE death but not real | JENCE OF): | 26. P | g couse | CQ given in F | Pert I. 24a. WAS APPERFOL 1 VES : ck only one) 5 Other (Specify) | I AUTOPSY RMED? | 24b. W A C C O 1 | Interval Between Onset and Death 1/2 Y S. VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
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| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH | B. DUE TO (DUE | (OR AS A CONSEQUE) (OR AS A CONS | JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JUNE OF) | 26. PHER: Nursing Horis 28c. IN W | LACE OF I | CQ given in F | Pert I. 24a. WAS APPERFOL 1 VES : ck only one) 5 Other (Specify) | I AUTOPSY TIMED? I NO | 24b. W A C C 1 | Interval Between Onset and Death '/c Y / 'S . VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentisliy list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 AGO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation 1 Suicide 1 Could not be detarmined 29a. CERTIFIER 1 CERTIFIED DAYS 29a. CERTIFIER 1 CERTIFIED DAYS 29a. CERTIFIER 1 CERTIFIED DAYS | B. DUE TO (DUE | (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU death but not real INJURY ay, Year) F INJURY — At hometic. (Specify) | JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JUNE OF INJURY JUNE OF INJURY | 26. P HER: Nursing Hor 28c. IN M 1 t, factory, office | LACE OF E | GQ given in F | Pert I. 24a. WAS AN PERFO 1 VES : ck only one) 3 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | I AUTOPSY RMED? I NO INJURY OCC | 24b. W A C C O 1 | Interval Between Onset and Death '/c Y / 'S . VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending investigation 3 Suicide 8 Could not be detarmined | B. DUE TO (b. DUE TO (c. DUE TO (d. DUE TO (d. DUE TO (d. DUE TO (d. DUE TO (d. DUE TO (d. DUE TO (d. DUE TO (d. D. DATE OF (Month, D. D. DATE OF (Month, D. D. DATE OF (Month, D. D. D. D. D. D. D. D. D. D. D. D. D. | (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU (OR AS A CONSEQU death but not rae ER/Outpettent 3 INJURY (Specify) FINJURY — At home etc. (Specify) | DENCE OF): DENCE OF): DENCE OF): Builting in the dence of the decent of the occurred at the | 26. P HER: Nursing Hor 28c. IN M 1 the time, det | LACE OF I | given in F | Pert I. 24a. WAS AN PERFO 1 YES : Ck only one) 3 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Town, State | I AUTOPSY RMED? I NO INJURY OCC and Number | 24b. WARED 1 24b. WARED O Rurel Rocked. | Interval Between Onset and Death I/C Y/CS. VERE AUTOPSY FINDINGS MAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES 2 NO |
| D BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Security of the determined Pendickle Security one Pending Investigation Pendickle Security one Pending | B. DUE TO (b. DUE TO (c. DUE TO (d | GOR AS A CONSEQUE (OR AS A CONS | JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JUNE OF INJURY Le, farm, stree Ith occurred at weatigation, in | 26. P HER: Nursing Hor 28c. IN W M 1 t, fectory, offi | LACE OF E | given in F | Pert I. 24a. WAS AP PERFO 1 YES : Ck only one) B Other (Specify) 28d. DESCRIBE HOW 26f. LOCATION (Street City or Town, State to the cause(a) and matima, date and placa, a | I AUTOPSY IMED? INJURY OCC and Number Inner as state odus to the | 24b. W A C O O 1 CURED Or Rural Roc ed. e cause(s) s | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO |
| ED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Security of the determined Pendickle Security one Pending Investigation Pendickle Security one Pending | B. DUE TO (b. DUE TO (c. DUE TO (d | GOR AS A CONSEQUE (OR AS A CONS | JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JUNE OF INJURY Le, farm, stree Ith occurred at weatigation, in | 26. P HER: Nursing Hor 28c. IN W M 1 t, fectory, offi | LACE OF E | given in F | Pert I. 24a. WAS AP PERFO 1 YES : Ck only one) B Other (Specify) 28d. DESCRIBE HOW 26f. LOCATION (Street City or Town, State to the cause(a) and matima, date and placa, a | I AUTOPSY IMED? INJURY OCC and Number Inner as state odus to the | 24b. W A C O O 1 CURED Or Rural Roc ed. e cause(s) s | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO |
| COMPLETED BY PHYSICIAN: MEDICAL | IMMEDIATE CAUSE (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant condition 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO 27. MANNER OF DEATH 1 Natural 5 Pending Investigation Security of the determined Pendickle Security one Pending Investigation Pendickle Security one Pending | B. DUE TO (b. DUE TO (c. DUE TO (d | GOR AS A CONSEQUE (OR AS A CONS | JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JENCE OF): JUNE OF INJURY Le, farm, stree Ith occurred at weatigation, in | 26. P HER: Nursing Hor 28c. IN W M 1 t, fectory, offi | LACE OF E | given in F | Pert I. 24a. WAS AN PERFO 1 TYES: ck only one) 5 Other (Specify) 28d. DESCRIBE HOW 28f. LOCATION (Street City or Rown, State to the cause(s) and ma | I AUTOPSY IMED? INJURY OCC and Number Inner as state odus to the | 24b. W A C O O 1 CURED Or Rural Roc ed. e cause(s) s | VERE AUTOPSY FINDINGS MAILABLE PRIOR TO OMPLETION OF CAUSE OF DEATH? YES 2 NO |



2

30. NAME AND ADDRESS OF PERSON(WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

01/1

7801

Branch Ave. #409 Clinton, Maryland

| DALLIMONE, MANTLAND 41203-5140 | 24 mours after death. Page 6 may be retained by the hospital or attending physician. | filled in by the funeral director, page 5 should be detached for use as the burial-transit p on, or removal. | he medical examiner must be notified at once. |
|--|---|--|--|
| DIVISION OF VITAL RECORDS, F.C. BOA 13148, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24-mours after death. Page 6 may be retained by the hospital or attending physician. | THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit per filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

| | FOR 1 - STATE REGISTRAR | STATE OF N | | | TMENT OF H | | MENTAL HYGIEN | E 4 | 30- | 34486 | |
|---------------|--|--|---|--------------------------------|--|---|--|--|----------|---|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF DEATH | | 1 3 | TIME OF DEATH | |
| | JESSIE | RHAMES | | | | | | MONTH DAY YEAR 5.15TD | | | |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | B. AGE (In yrs. i | | IF UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH | 199 | | ACE (State or Foreign | |
| | 224-05-4519 | M 2 □ F | 82 | YRS. | MONTHS DAYS | HOURS MIN. | (Month, Day, Year) Sept. 27 | 2000 | Country) | Carolina | |
| | 9e. FACILITY NAME (If not institution, give a | treat and number) | | | 9b. CITY, TOWN (| OR LOCATION OF D | | 9c. COUNT | | | |
| DIRECTOR | Southern Maryla | pital | | Clint | on | | Prin | ce | George's | | |
| Б | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | , | | 10c CIT | Y, TOWN OR LOCAT | ION | | | L | od. INSIDE CITY | |
| Ē | Complete Com | e George | l c | | Clinton | | | | | LIMITS? | |
| | 10e. STREET AND NUMBER | e George | <u> </u> | | | | | | | YES 2 X NO | |
| ₹ | | _ | | | 101 | ZIP CODE | | | | AT COUNTRY? | |
| 單 | 9106 Pineview | Lane | | | | 20735 | | Uni | .ted | States | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 1 | | If yes, sp | ENDENT OF HISPA ecity Cuben, Mexic 2 NO Speci | NIC ORIGIN? (Specify Yes en, Puerto Rican, atc.) fy: | or No— | Black, | - American Indien, White, atc. | |
| 0 | 15. DECEDENT'S EDU | CATION | 16a, I | DECEDENT'S | USUAL OCCUPATION | ON | 16b. KIND OF BU | SINESS/INDU | STRY | | |
| H | (Specify only highest grade Elementary/Secondary (0-12) | | | (Give kind of ife. Do NOT u | work done during mo se retired.) | st of working | | | | | |
| 7 | | College (1-4 or 5 | | acto | ry Worl | cer | Priva | a+o | | | |
| COMPLETED | 4th Grade 17. FATHER'S NAME (First, Middle, Lest) | | | ucco | Ty WOL | | AME (First, Middle, Melden | | | | |
| 8 | The table of the second of the | - | | | | 32,002,1102,110 | | Surrierner) | | | |
| B | Jessie Rhame: | 5 | | | | | Prince | | | | |
| 2 | and the second s | | | | | | Route Number, City or Tox | | | | |
| - | Pearline Gilchrist 1204 Castlewood Dr., Upper Marlboro, MD. | | | | | | | | | | |
| | 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or control of their place) 20c. LOCATION — City or Town, State | | | | | | | | | | |
| | 4 Donation 5 Other (Specify) | | _ Coc | per | Cemete | | | llins | , S | .C. | |
| - 1 | 21. SIGNATURE OF FINERAL SERVICE CO | CENSEE 01 | 1 | | 22 STAME A | Vart Fu | neral Ho | ne | | | |
| | · lopn ! | Lu | unt 5 | Ш | | | ng Road, | | Wa | sh.D.C. | |
| | interval Be Onset and | | | | | | | Approximate Interval Between Onset and Death | | | |
| | disesse of condition resulting in death) | SDUE TO | RESPIRATORY ARREST DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | - | |
| NO | Sequentially list conditions, If any, leading to immediate cause. Enter UNDERLYING | | | | | | | - | | | |
| CATI | | | | | | | | | | | |
| CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in deeth) LAST | DUE TO | (OR AS A CONS | SEOUENCE C | PF): | | | | | | |
| 빙 | | u | | | | | | | | | |
| AL | PART II. Other significent condition | s contributing to | death but no | t resulting | in the underlyin | g ceuse given l | Part I. 24a, WAS AI | | | WERE AUTOPSY FINGINGS AVAILABLE PRIOR TO | |
| MEDICAL | Possible L | ing Can | cer | | | | 1 _ YES | | | COMPLETION OF CAUSE OF DEATH? | |
| 쁘 | Dementia | , | | | | | | | - 1 | YES 2 NO | |
| 2 | | | | | | | | | | | |
| A | 25. WAS CASE REFERRED TO MEDICAL | 1 | | | 26 P | LACE OF DEATH (C | theck and anel | - | | | |
| <u> </u> | EXAMINER? | HOSPITAL: | | - 37 | OTHER: | ENOE OF BEATH (C | riack only only | | | | |
| PHYSICIAN: | 1 YES 2 NO | X□ Inpatient 2 | | _ | | | 6 Other (Specify) | | | | |
| ВУ РН | 1 Netural 5 Pending 2 Accident Investigation | 26e. DATE Of (Month, I | Day, Year) | 26b. TII | JURY W | JURY AT ORK? YES 2 NO | 26d. DEŞCRIBE HOW | INJURY OCC | URED | | |
| 0 | 3 Suicide 6 Could not be 4 Homicide determined | 28e. PLACE (building | OF INJURY — At , etc. (Specify) | home, farm, | street, factory, offic | 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) | | | | | |
| COMPLETE | (0.000, 0.00) | | | | | | e to the ceuse(e) end me | | | | |
| Š | one) 2 MEDICAL EXAMIN | ER: On the beele of | examination end/ | or Investigat | lon, in my opinion, | death occured at th | e time, date end place, e | nd due to the | ceuse(e) | end manner ee stated. | |
| ш | 29b. SIGNATURE AND TITLE OF CERTIFIE | 1/1/0\10 | Min | 1 1 | | 29c. LICENSE N | JMBER | 29d. DATE | SIGNED (| Month, Day, Year) | |
| 00 | | 1 8 8 ES-76 /S | 1 411-114-112 | 7 | The same of the sa | | _ | D 2 | | | |

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11/27/1990

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r

|) 21203-3146 | r attending physician. |
|-------------------|---------------------------------|
| 5 | 0 |
| 4D 2 | hospital o |
| A | he |
| تے | 3 |
| MARYLAND | Page 6 may be retained by the h |
| | pe |
| Ä | may |
| Ö | 9 |
| ž | Page |
| BALTIMORE | death. |
| $\mathbf{\alpha}$ | ter |

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 flours after death. Page 6 may be retained by the hospital or attending physician.

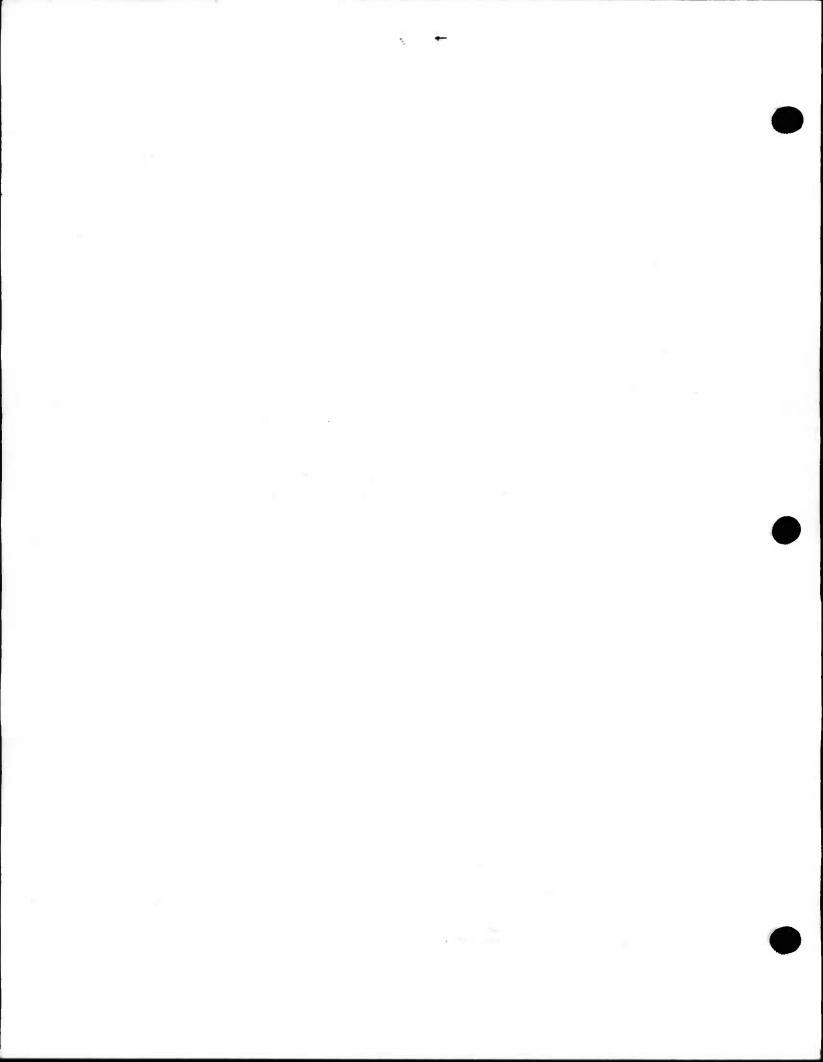
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, be filled within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | OIAIL OI WAN | | | | DEATH | REG. N | 0. | | | |
|--------------------|---|---|---|-----------------|-------------|--------------------------------------|---|---------------------|-------------------|--|-------|
| 1 | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 1100 | 2. OATE OF OEATH MONTN | DAY | YEAR | 3. TIME OF OEATH | |
| | ERNEST LEE | RHODES | | | | | | 28 | 90 | 1142 | М |
| | 4. SOCIAL SECURITY NUMBER | 1,700 | GE (In yrs. leat birthday, | MONTHS | 1 YEAR | IF UNDER 24 NRS. HOURS MIN. | 7. DATE OF BIRTH (Mgnth, Day, Year) | , | 8. BIRTI Count | HPLACE (State or Foreigny) | gn |
| | 579-01-8730 | 1 [X M 2 □ F | 86 YRS. | MONTHS | DATO | noons wiin. | (Month, Day, Year) 06-25-(|) 4 | VIR | ĞINIA | |
| | 8a. FACILITY NAME (If not institution, give si | | | | | R LOCATION OF DE | ATH | 9c. CO | UNTY OF E | DEATH | |
| <u></u> | 3721 Park Driv | e | | F | Edge | ewater | | F | λA | | |
| FUNERAL DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | γ | 10c. Ci | ITY, TOWN C | R LOCAT | ION | | | | 10d. INSIDE CITY | |
| <u>۳</u> | MD ANNE | ARUNDEL | EDO | GEWA: | FER | | | | | LIMITS? 1 YES 2 NO | 0 |
| ا تِ | 10e. STREET AND NUMBER | ANONDEL | TBD(| 30 11 11 | _ | . ZIP CODE | | 10g. Ci | ITIZEN OF | WHAT COUNTRY? | |
| 2 | 3721 Park Dri | VA | | | | 21037 | | | USA | | |
| 3 | 11. MARITAL STATUS | 12. WAS DECEDENT EV | ER IN U.S.ARMED | | WAS DEC | ENDENT OF HISPAN | IIC ORIGIN? (Specify | fan or No | 14. RAC | E — American Indien, | |
| B | 1 Never Married 2 Married WWW.Widowed 4 Divorced | FORCES? 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 | | | | ecify Cuban, Maxica 2X NO Specify | n, Puarto Rican, atc.) /: | | Spec | k, white, alc. Sily: White | |
| 요 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION completed | 16a. DECEDENT | S USUAL O | CCUPATIO | ON st of working | 18b, KIND OF E | USINESS/II | NDUSTRY | WILL O'C | |
| COMPLETED | Elemantery/Secondary (0-12) | College (1-4 or 5+) | life. Do NOT | use retired.) | ouring inc | St Of Working | | | | | |
| M M | 12 | 5+ | Lawye | r | | | U.S | . Go | v¹t. | | |
| ဂွ် | 17. FATHER'S NAME (First, Middle, Last) | | | | | | ME (First, Middle, Maid | en Sumame, |) | | |
| BE | Homer Whitefie | ld Rhodes | 3 | | | LULA | BEERY | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | | | | | | Route Number, City or 1 | | | 2089 | 95 |
| - | Kenneth Lee Rh | odes | | | | | Drive, 1 | | | | |
| | 20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Rema | | 20b. PLACE OF DISP | | | | | | — City or T | | |
| | 4 Donation 5 Other (Specify) 1. SIGNATURE OF PUNERAL SERVICE LIC | | HILLCI | | | metery | | napo | lis, | MD | |
| | 21. SIGNATURE OF PAREMAE SERVICE OF | 1/1/ | | | | DESTY F | UNERAL | HOME | P | Δ | |
| | vall H | and | | | | | | | | LIS. MD | |
| CERTIFICATION | iMMEDIATE CAUSE (Final disease or condition resulting in deeth) Sequentielly liet conditione, if eny, leeding to immediata ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in deeth) LAST | b. ASCVI | Myocar as a consequence as a consequence as a consequence | OF): | In | f <i>RAC</i> tio | on | | | Oneat end (|)eeth |
| 5 | | a | | | | | | | | | |
| PHYSICIAN: MEDICAL | PART ii. Other significant condition | ns contributing to dea | ith but not resulting | g in the ur | nderlyin | g cause given in | PERI | AN AUTOPS ORMED? | 24 | b. WERE AUTOPSY FINI AWAILABLE PRIOR TO COMPLETION OF CAI OF DEATH? 1 YES 2 NO | USE |
| MAI | 25. WAS CASE REFERRED TO MEDICAL | | | | | LACE OF DEATH (Ch | eck only one) | | | | |
| Sic | EXAMINER? 1 YES 2 NO | HOSPITAL: 1 inpatient 2 ER | /Outpatient 3 🗆 DOA | OTHEI | | ne 5 Realdence | a Other (Specify) | | | | |
| ž | 27. MANNER OF DEATH | 28a. DATE OF INJU (Month, Day, Y | URY 28b. T | IME OF NJURY | 28c. IN | JURY AT | 28d, DEŞCRIBE HO | W INJURY C | OCCURED | | |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | | М | | YES 2 NO | | | | | |
| | 3 Suicida a Could not be 4 Homicide detarmined | 28e. PLACE OF IN- building, aic. | JURY — At home, ferm (Specify) | n, street, fec | tory, offic | ca | 281. LOCATION (Stree City or Town, Str | | ber or Rural | Route Number, | |
| COMPLETED | one) | ER: On the beat of my | | | | | | | | (a) and manner as stat | ted. |
| | 29b. SIGNATURE AND TITLE OF CERTIFIE | 2 | -0 | | | 28c. LICENSE NUI | MBER | 29d. O | ATE SIGNE | D (Month, Day, Year) | |
|) BE | Millent | The same | U/ De | puty | | D 060 | 54 | | 11 - 2 | 28-90 | |
| 5 | 30. NAME AND ADDRESS OF PERSON WE William P. | | | | ric | a Court | David | sonv | ille | e, Md 21 | 03 |
| | 31. DATE FILED (Month, Day, Year) | 32 REGISTRAR'S | SIGNATURE | • " | | | | | | | |
| | DEC 0.3 199 | 11 Julia Davi | don-pondell | 6 | | | | | | | |

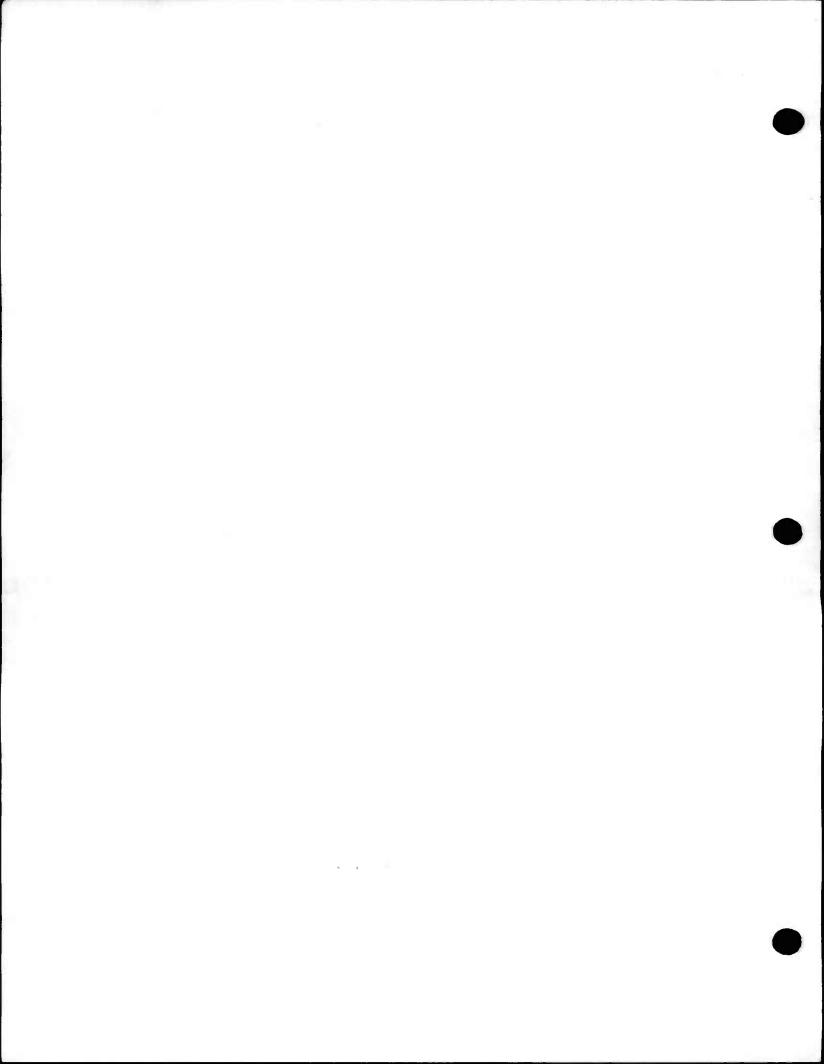


| 1 | 3 | 12 | | (|
|--|---|--|--|--|
| 13146, BALTIMORE, MARYLAND 21203-3146 | VG PHYSICIAN: The law requires that the death certificate be executed within 24 mours after death. Page 6 may be retained by the hospital or attending physician. | ther this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit, Pages 1, 2 and sath with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | atic event, the medical examiner must be notified at once. | MONTH IN THE PARTY OF THE PARTY |
| DIVISION OF VITAL RECORDS, P.O. BOX 13146, | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the be filed within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | TO BE COMPLETED BY DHYSICIAN: MEDICAL CEDTIFICATION |

| 1.0 | STATE REGISTRAR DECEDENT'S NAME (First, Middle, Last) | | | | CATE C | F HEALTH AND | | REG. NO. | | / 901 | 3. TIME OF DEATHO |
|-------|--|---|--------------------------|-------------------|----------------|--|----------|--|------------|--------------|---|
| | EDU | | aige | | HARD. | | Mo | 1 20 | 1 . | 9 YEAR | 6:50 P M |
| | 20-32-2089 | 5. SEX 6. | AGE (In yrs. | · · · | IF UNDER 1 YE | | (M | te of Birth lonth, Day, Year) | .19 | Country | PLACE (State or Foreign |
| | FACILITY NAME (If not institution, give str | | | | | VN OR LOCATION OF D | | - 12 | | NTY OF DE | |
| | Dorchester Gen | eral Hos | spita | al | Cai | nbridge | | | | Dorc | hester |
| 10e. | . STATE 106. COUNTY | XXXXXX DORCH | ESTER | | mbri | | | | | ŀ | 10d. INSIDE CITY LIMITS? |
| - | STREET AND NUMBER | | | | | 101. ZIP CODE | | | 10g. CIT | | XX YES 2 ☐ NO |
| 5 | 511 Edlon Park | | | | | 21613 | | | | US | |
| 1 🗆 | MARITAL STATUS Never Married 2 Merried Wildowed 4 Divorced | 12. WAS DECEDENT E FORCES? 1 IF YES, GIVE WAR | YES 2 | ARMED NO | If yes | DECENDENT OF NISPA I, specify Cuben, Mexico YES 2 NO Specifi | n, Puer | | or No— | | - American Indian, white, atc. |
| | 15. DECEDENT'S EDUC. (Specify only highest grade of | | 16a. | DECEDENT'S U | | | Т | 16b. KIND OF BUS | INESS/INI | DUSTRY | |
| | Elementary/Secondary (0-12) | College (1-4 or 5+) | \dashv | Ille. Do NOT use | retired.) | most of working | | | | | |
| | 12 | | Jι | ıvenil | le S | ervices | | Sta | te : | Empl | oyee |
| 17, 1 | FATHER'S NAME (First, Middle, Last) | | | | | 18. MOTHER'S NA | ME (Fin | st, Middle, Maiden S | Sumame) | | |
| | Edward Levin | Richarso | lon | | | | | loe Cov | | | |
| | . INFORMANT'S NAME (Type/Print) Joyce C. Richa | 2000 | | | | eet and Number or Rural | | | | , | 64.0 |
| | METNOD OF DISPOSITION | ruson | 20b DI A | | | n Park Ca | amb | | | City or Ton | |
| 1 (X | Buriel 2 Cremation 3 Remo | val from State | othe | r place) | | Cemetery | | | | | |
| | SIGNATURE OF THERAL SERVICE LICE | NSEE | Labi | . Inq_n | 22. NAM | E AND ADDRESS OF FA | CILITY | Eas | ton | ,_Ma | |
| | · With |) | | | 701 | E AND ADDRESS OF FA | a t | Thomas | Fu | nera | I Home |
| 22 | . PART I. Inner the diseases, or co | amplications that a | nunnel the | dooth Do o | | | | | | | Md. 21613 |
| 1 23. | shock, or heart fallure. L | ist only one cause | on each I | line | | | | | | | Approximate Interval Between |
| | MEDIATE CAUSE (Final sease or condition | 1 | 3.0 | Haopr | agea | l Carcin Couch astatic | ome | a with | 1 | , | Onset and Death |
| res | sulting in death) | DUE TO (O | R AS A CON | SEQUENCEOF | al | cuan | Sm | 1a u | 7/14 | | 2190 |
| | | | ME | TAST | 7777 | SPECH | Spi | reau | | | į |
| | equentially list conditions, any, leading to immediate | DUE TO (O | AS A CON | SEOUENCE OF | : | | | | | | |
| cau | use. Enter UNDERLYING | • | | | | | | | | | |
| tha | at initiated events | DUE TO (O | AS A CON | SEOUENCE OF) | : | | | | | | |
| 100 | d d | 1 | | | | | | | | | |
| PA | RT il. Other significant conditions | contributing to de | ath but n | ot resulting in | the under | lying cause given in | Part I | . 24e, WAS AN | NUTOPSY | 24b. | WERE AUTOPSY FINDINGS |
| 1 . | NIDDM | | | | | | | PERFORI | | | AVAILABLE PRIOR TO COMPLETION OF CAUSE |
| | 40° | | | | | | | | | | OF DEATN? 1 YES 2 NO |
| | | | | | | | _ | | | | |
| 25. | WAS CASE REFERRED TO MEDICAL EXAMINER? | | | | | 8. PLACE OF DEATN (C/ | eck only | y one) | | | |
| | | HOSPITAL: 1 Inpatient 2 LE | R/Outpatien | | OTHER: | Nome 5 🗆 Residence | s 🗆 o | Other (Specify) | | | |
| III . | MANNER OF DEATN | 28e. DATE OF IN (Month, Day, | JURY Year) | 28b. TIME INJU | OF 28c | INJURY AT WORK? | 28d. | DEȘCRIBE NOW IN | JURY OC | CURED | |
| | 1 Naturel 5 Pending 2 Accident Investigation | | | | | YES 2 NO | | | | | |
| III. | Suicide S Could not be determined | 28e. PLACE OF I building, etc | NJURY — A . (Specify) | t home, farm, at | reet, fectory, | office | | LOCATION (Street e City or Town, State) | nd Numbe | or Aurel A | loute Number, |
| - | | | | | | | | | | | |
| 298. | (Check only one) | | | | | | | | | | |
| | 2 MEDICAL EXAMINER | t: On the basis of exam | nination end | /or investigation | , in my opini | on, death occured at the | time, o | date end place, end | f due to t | he ceuse(a) |) end manner se stated. |
| 296 | SIGNATURE AND TITLE OF CERTIFIER | Ly Au | gert | Fiery | M. | 29c. LICENSE NU | MBER | | 29d. DAT | TE SIGNED | (Month, Day, Year) |
| III. | unna | + Kl | N | 1 h | (A) | 1122 | 17 | 3 | - 1 | 1129 | 190 |
| | NAME AND ADDRESS OF PERSON WIND | | | | | | _ | | | | |

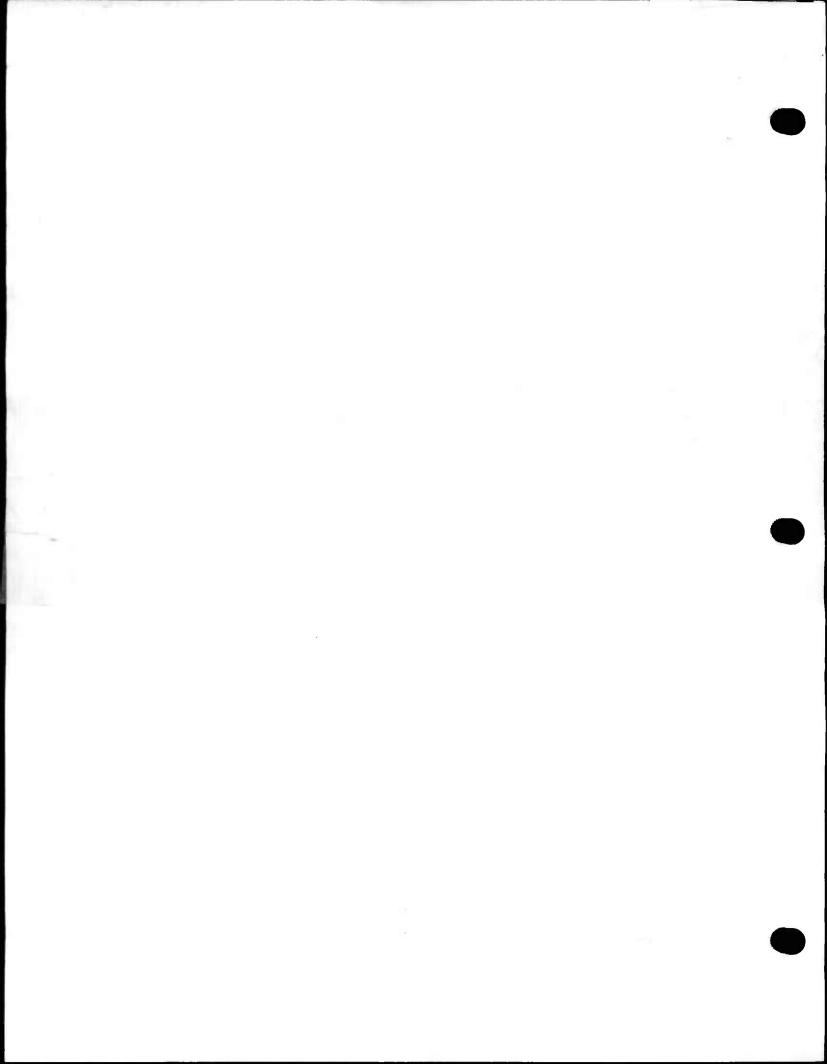
Mandalle

16ar) 3 '90



| | TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2-mouns after death. Page 6 may be retained by the hos | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detache be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. | IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
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| , | G P! | er th | Jark |
|) | NO | Aft | 18 |
| 5 | III. | afte afte | 28 |
| | OR A | TO THE FUNERAL ORECTOR: After this certificate has been signed by the attending physician and completely filled in by the f be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. | Ea |
| 2 | TAL (| A Z | E |
| | SP | INER | H. |
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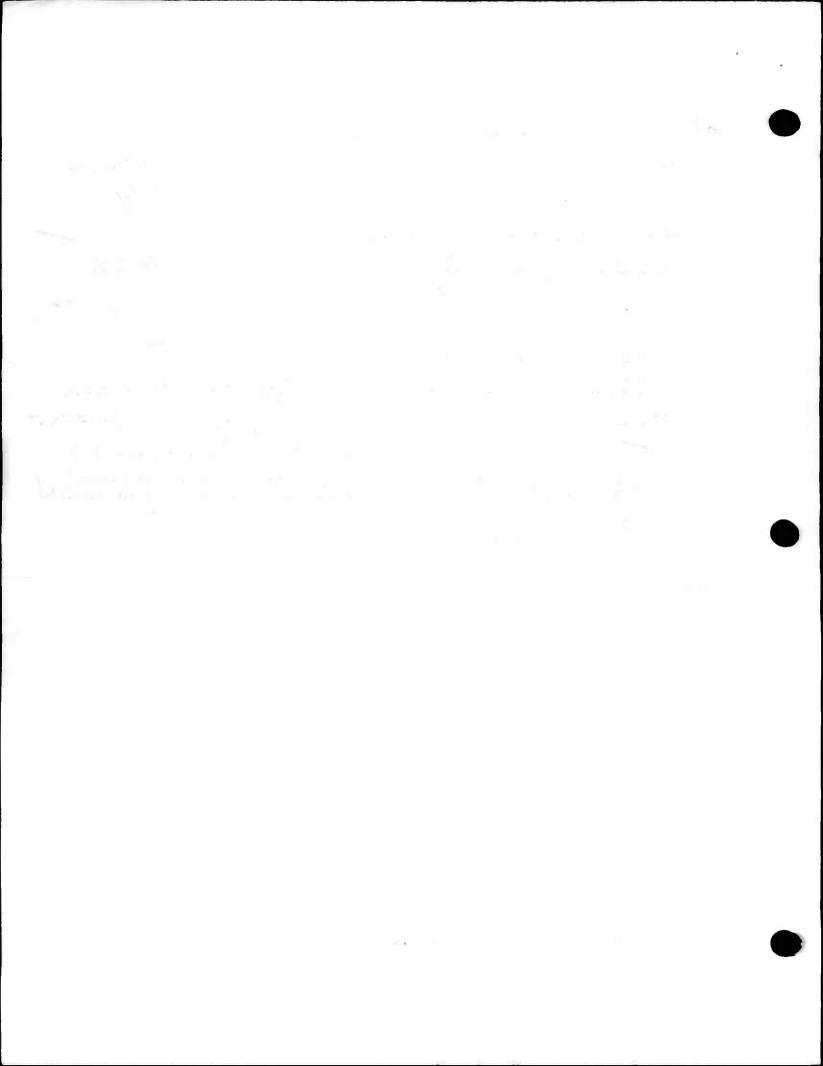
| | FOR 1 - STATE REGISTRAR | STATE OF MARYLAND | / DEPARTM | | | | YGIENE EG. NO. | 90 | 34489 |
|--------------------|--|---|--|-----------------------|---|----------------------------|---|---------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | 2. OATE OF | DEATH DAY | YEAR | 3. TIME OF OEATH |
| | DEBORAH | ANNE RYAN | | 100 | _ | 11-2 | 26-90 | | 2:28PM M |
| . 1 | | 5. SEX 8. AGE (In yrs. | 1404 | UNDER 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF E (Month, De | | 8. BIRT | THPLACE (State or Foreign ntry) |
| | 217 00 0333 | 1 □ M 2 💢 F 30 | YRS. | 2000 | E-8/30/ | | 2,1960 | Ва | lto. Md. |
| TOR | 90. FACILITY NAME (IT not institution, give stre Johns Hopkins Hos | | 96. | | ltimore | | 90. | City | |
| DIRECTOR | 10a. STATE 10b. COUNTY | Ltimore | | wn on Locat | | | | | 10d. INSIDE CITY LIMITS? 1 YES 2 X NO |
| | 10e. STREET AND NUMBER | | | 101 | ZIP COOE | | 10g. | CITIZEN OF | WHAT COUNTRY? |
| E | 335 Highfalcor | ı Road | | | 21136 | | | | USA |
| BY FUNERAL | | 12. WAS OECEOENT EVER IN U.S. FORCES? 1 YES 2 IF YES, GIVE WAR OR OATES | | tf yes, spe | ENDENT OF HISPAN ocity Cuban, Mexica 2 X NO Specify | n, Puarto Rica | | Ble | CE American Indian, ick, Whita, atc. acity; hite |
| COMPLETED | 15. DECEDENT'S EDUCA (Specify only highest grade of | completed) | DECEDENT'S USU (Give kind of work life. Do NOT use rel | done durina mai | N st of working | 16b. KIP | OF BUSINES | S/INDUSTRY | |
| 7 | Elementary/Secondary (0-12) High School | College (1-4 or 5+) | | sewife | | | | | |
| MO | 17. FATHER'S NAME (First, Middle, Last) | | 1100 | DEWILL | 18. MOTHER'S NA | ME (First, Midd | le, Maiden Sumai | me) | |
| | David M. Woodwar | d Sr. | | | Barba | ra Ta | aylor | | |
| BE | 19a. INFORMANT'S NAME (Type/Print) | I | 19b. MAILING ADI | ORESS (Street a | nd Number or Rural I | Route Number, | City or Town, Stat | te, Zip Code) | |
| 2 | David M. Woodward | Sr. | 335 Hi | ghfalc | on Rd. R | Reister | rstown, | Md. | 21136 |
| | 20e. METHOD OF DISPOSITION PCXBurlel 2 Cremetton 3 Remove 4 Donatton 5 Other (Specify) | vat from State othe | ce of disposition of place) | , | netery, cremetory or Veterans | . Cem. | 20c. LOCATIO | • | Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | | | | O ADDRESS OF FA | | | | erstown Rd. |
| | fam B | line | | Eline | Funeral | Home | | | n, Md. 21136 |
| Z | IMMEDIATE CAUSE (Finel | lat only one cause on each in Narcotic Int | oxicatio | | ae or dying, suc | n ss cerdiec | or respirator | y sireet, | Approximate Interval Between Onset and Death |
| CERTIFICATION | Sequentially list conditione, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events rasulting in death) LAST | OUE TO (OR AS A CON | | | | | | | |
| PHYSICIAN: MEDICAL | PART II. Other significent conditions History of drug | CONTRIBUTING to deeth but no | ot resulting in t | ne underlying | g ceuse given in | | e. WAS AN AUTO PERFORMEDI YES 2 N | | 4b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF GEATH? 本述 YES 2 □ NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | | 26 81 | ACE OF DEATH (Ch | eck only one! | | | |
| S | EXAMINER? | HOSPITAL: | | THER: | | | to a still t | | |
| H | 27. MANNER OF DEATH | 1 Inpatiant 2 ER/Outpation 28s. DATE OF INJURY | 28b. TIME O | F 28c. INJ | e 5 🗆 Rasidence | | pecify) IBE HOW INJUR | Y OCCURED | |
| ВУ РІ | 1 Natural 5 Pending 2 Accident Investigation | 1114026490 | thJURY | M 1 🗆 | PRK? YES 2 XXNO | Unkn | | | |
| | 3 Suicide Could not be 4 Homicide determined | 28a. PLACE OF INJURY — A building, atc. (Specify) | | at, factory, official | | 1822° | on (Street and Ni fown, State) Rut.land | Ave. | n Route Number, ,Baltimore,MI |
| COMPLETED | cool only | CIAN: To the best of my knowledge 3: On the basis of examination and | | | | to the cause(| a) and mannar a | n stated. | |
| BE | 2013 ATTHAT LINE AND OFFICE OF CERTIFIES | n | | | 29c. LICENSE NUI | MBER | 290 | | ED (Month, Day, Year) 26-90 |
| 10 | 30.1 MAME AND ADDRESS OF PERSON WHO FRANK PERETTI, MD | COMPLETED CAUSE OF DEATH | | | reet,Bal | ltimore | e,MD 21 | | Vo |
| | NOV 2.9 90 | 32. REGISTRAR'S SIGNATUR | - Mandall | r | | | | | |



| Pages 1 | | |
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| permit. | | |
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| ficate h | State [| ed, or Item 23 shows any Injury, or other |
| his certi | with the | ced, or |
| After th | death with | s mari |
| RECTOR: | irs after | NT: If item 28 Is marked, |
| TAL DIR | 72 hou | If iter |
| FUNE | * | STANT: |
| THE CH | be filed | IMPO |

34490 90 STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | FOR STATE REGISTRAR | STATE OF MARYLAND / DEPARTM CERTIFICA | ENT OF HEALTH AND MATE OF DEATH | IENTAL HYGIENE 9 | 34490 |
|-----------------|---|--|--|---|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | 2. DATE OF DEATH | 3. TIME OF DEATN |
| Ì | STEPHEN | ALAN SAUND | ERS | | 6 345 AM |
| | | | UNDER 1 YEAR IF UNDER 24 HRS. | 7. DATE OF BIRTN 8. (Month, Day, Year) | BIRTNPLACE (State or Foreign Country) |
| | 496-50-0099 10 | XM2 ☐ F 45 YRS. MON | THS DAYS HOURS MIN. | 1-4-45 | MISSOULI |
| 47 | 9e. FACILITY NAME (If not Institution, give street a | and number) 9b. | CITY, TOWN OR LOCATION OF DEA | 01 | |
| DIRECTOR | RESIDENCE OF DECEDENT | Hospice | BALTIMORE | City C | 114. |
| EG | 100. STATE 100, COUNTY | 10c. CITY, TO | WN OR LOCATION | | 10d. INSIDE CITY LIMITS? |
| E | me BAI | Itimore U, | operco | | 1 YES 2 Z |
| A. | 10e. STREET AND NUMBER | · I DI | 101. ZIP CODE | 10g. CITIZER | OF WHAT COUNTRY? |
| FUNERAL | 5226 Bi | jerly ker | 21153 | | (.5/2 |
| ᆵ | 1 Nover Married 2 Married | WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 TYES 2 NO | 13. WAS DECENDENT OF NISPANI If yes, specify Cuben, Maxican | , Puerto Ricen, etc.) | . RACE — Americen Indian, Black, White, etc. |
| B | 3 Wildowed 4 Divorced | IF YES, GIVE WAR OR DATES | 1 YES 2 NO Specify: | | Specify: White |
| | 15. DECEDENT'S EDUCATIO (Specify only highest grade comp | ON 18e. DECEDENT'S USU | AL OCCUPATION done during most of working | 18b. KIND OF BUSINESS/INDUS | TRY |
| 91 | | ollege (1-4 or 5+) | ired.) | Comput | EVS |
| COMPLETED | 12 | 6 Progr. | Amei | | |
| | 17. FATHER'S NAME (First, Middle, Last) | 5. 1. | 16. MOTNER'S NAM | IE (First, Middle, Malden Sumame) | 100000 |
| H | 19e. INFORMANT'S NAME (Type/Print) | JAUN devs | DESC (Stand and Mumber or Burning | oute Number, City or Town, State, Zip Co | Verson |
| 2 | | ov.il 5226 | B. E. L. D. | d. Upperco | 111-1 = 1100 |
| - 1 | 20e. METHOD OF DISPOSITION | 20b. PLACE OF DISPOSITIO | N (Name of cemetery, crematory or | 200. LOCATION — CIT | |
| | 1 Donation 5 Other (Specify) | trom State other place) | Crema tou | 6 BAltin | ove Wd. |
| i | 21. SIGNATURE OF FUNERAL SERVICE LICENS | EE / /A | 22. NAME AND ADDRESS OF FAG | | alibel |
| | 1 Hy, Zel | lact | ILGO POI | - tunent | chille und |
| | | plicetione that caused the deeth. Do not | anter the mode of dying, euch | as cerdiec or respiratory erres | |
| | shock for heert feliure. List iMMEDIATE CAUSE (Final | only one ceuee on each line. | | | interval Between Onset and Daeth |
| | disease or condition resulting in deeth) s | Retrovual or | rection | | |
| | | DUE TO (OR AS A CONSEQUENCE OF): | 1 | | |
| NO | Sequentleily liet conditions, b. | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| ATI | if any, leading to immediate cause. Enter UNDERLYING | DUE TO (ON AS A CONSEQUENCE OF): | | | į į |
| 밀 | CAUSE (Disease or injury that initiated evants | DUE TO (OR AS A CONSEQUENCE OF): | | | |
| CERTIFICATION | resulting in death) LAST | | | | |
| | PART ii. Other significant conditions of | ontributing to death but not resulting in the | he underlying cause given in | Part I. 24e. WAS AN AUTOPSY | 24b. WERE AUTOPSY FINDINGS |
| CAL | | | and and anything databas given in | PERFORMED? | AVAILABLE PRIOR TO COMPLETION DF CAUSE |
| PHYSICIAN: MEDI | | | | 1 [] YES 2 [] NO | OF DEATN? |
| X | | | | - | T TES 2 NO |
| AN | 25. WAS CASE REFERRED TO MEDICAL | | 26. PLACE OF DEATN (Che | ock only one) | |
| Sic | | | THER: Nursing Home 5 Residence | 8 Other (Specify) | |
| 美 | 27. MANNER OF DEATN | 28s. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY | | 28d. DESCRIBE NOW INJURY OCCU | RED |
| ВУ | 1 Natural 5 Pending 2 Accident Investigation | | M 1 YES 2 NO | | |
| | 3 Suicide 8 Could not be | 28e. PLACE OF INJURY — At home, farm, stree building, etc. (Specify) | rt, factory, office | 28t. LOCATION (Street end Number or City or Town, State) | Rural Route Number, |
| COMPLETED | | | | | |
| 됩 | cont only | N: To the best of my knowledge, death occurred a | | | |
| ő | 2 MEDICAL EXAMINER: O | On the beale of examination end/or investigation, is | n my opinion, deeth occured at the | time, date and place, end due to the | ceuse(e) end menner as stated. |
| BE (| 29b. SIGNATURE AND TITLE DF CONTIFIER | for mo | 29c. LICENSE NUM | BER 29d. DATE S | NGNED (Month, Day, Year) |
| 2 | 30 NAME AND ADDRESS OF BERSON WHO CO | OMPLETED CAUSE OF DEATN (ITEM 27) (Type, Pri | 2 60 | 701 | -01-10 |
| | DOU GCAS | | | S. Greene S | t, 21201 |
| | 31. DATE FILED (North, Day, Year) | 32. REGISTRAR'S SIGNATURE Julia Davidson Randall. | | | , |



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the bunal-transit permit. Pages 1, 2, 3 mm be filed within 72 hours after death with the State Dept. of Health and Mental Hyglene prior to bunal, cremation, or removal. IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notifiled at once. TO THE HOSPITAL DR ATTENDING PHYSICIAN; The law requires that the death certificate be executed within

BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

2

| | | | | | | | | | | 90 | 3449 | |
|------------|---|---|-------------------------------|--------------|--------------|--------------|--|--|-------------|------------|---------------------------------------|--------|
| | FOR 1 - STATE REGISTRAR | STATE OF M | | | | | EALTH AND N | MENTAL HYGIENI REG. NO. | E | | | |
| | 1. DECEDENT'S NAME (First, Middle, Last) | | _ | | | | | 2. DATE OF DEATH | | YEAR | 3. TIME OF DEATH | |
| | DOROTHY | CASH | - | | SW | ANN | N | | | 1990 | 7:35A | м |
| 1 | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. le | st birthday) | IF UNDER | 1 YEAR | IF UNDER 24 HRS. | 7. DATE OF BIRTH (Month, Day, Year) | | S. BIRTHI | PLACE (State or Foreign) | חק |
| / | 218-34-6014 | 1 🗆 M 2 🖵 F | 79 | YRS. | MONTHS | DAYS | HOURS MIN. | 6-11-191 | 11 | | yland | |
| | 9e. FACILITY NAME (If not institution, give si | treet and number) | | | 9b. CITY | , TOWN C | R LOCATION OF DE | ATH | 9c. COL | UNTY OF DE | ATH | |
| 5 | PHYSICIANS MEMO | RIAL HO | SPITAI | | LA | PL | ATA | | CH. | ARLE | S | |
| 54 | RESIDENCE OF DECEDENT | | | _ | | | | | | | | = |
| DIRECTOR | Maryland Cha | arles | | | ndia | | the state of the s | | | | 10d. INSIDE CITY LIMITS? 1 YES 2XXNC | |
| ا پر | 10e. STREET AND NUMBER | | | | | 101 | ZIP CODE | - | 10g. CI | TIZEN OF W | HAT COUNTRY? | |
| EB/ | Rt. l, Box 149-B, Jenkins Lane 20646 USA | | | | | | | | | | | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Merried 2 Merried 12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES 12. WAS DECEOENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, While, atc.) 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, While, atc.) 14. RACE — American in fives, specify Cuben, Maxican, Puarto Ricen, etc.) 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, While, atc.) 16. YES 2 NO Specify: 17. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yee or No-Black, While, atc.) | | | | | | , White, atc. | | | | | |
| COMPLETED | 15. DECEOENT'S EDU- (Specify only highest grade | CATION completed) | 16e. D | ECEDENT'S | USUAL C | CCUPATIO | ON st of working | 16b. KIND OF BUS | SINESS/IN | DUSTRY | | \Box |
| <u> </u> | Elementary/Secondary (0-12) | College (1-4 or 5 + |) | e. Do NOT u | se retired.) | | • | 1 | | | | l |
| M M | 12 | - | | Hous | ewi | r e | | Home | 9 | | | |
| ᅙᆡ | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 16. MOTHER'S NA | ME (First, Middle, Maiden | Sumeme) | | | |
| BE | Thomas Ford Cod | oksey | | | | | Nelli | ie Blumer | | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | -11 | 96. MAILING | ADDRES | \$ (Street a | nd Number or Rural i | Route Number, City or Tow | n, State, Z | Zip Code) | | |
| 2 | Thomas H. Swanr | ı, Jr. | f | Rt. | l, E | Зох | 149-B. | Indian H | lead | L. Md | 20640 | |
| | 20e. METHOD OF DISPOSITION 20b. PLACE OF DISPOSITION (Name of cametery, cramatory or other place) 20c. LOCATION — City or Town, State | | | | | | | | | | | |
| | Denellon 5 🗆 Other (Specify) | | Trin | nity | | | Ch. Cen | | por | t. M | aryland | |
| | 22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home | | | | | | | | | | | |
| | FIV 020 KZSI | Lons | 4 | > | P | | | al Home | rf | Md | 20604- | 01 |
| | 23. MRY Enter the diseases, or altock, or heart feilure. | complications that List only one cau | t caused the dise on each lin | leath. Do | not ante | r tha mo | da of dying, suc | h aa cardiac or reapi | iratory s | rreat, | Approximate interval Bets |) |
| | iMMEDIATE CAUSE (Finst disease or condition | Card | live. | an | Li | ,4 | ma | 6 | | | Onset and I | Death |
| | resulting in death) | OUE TO | (OR AS A CONS | EQUENCE O | 91/ | | 64 | t) | | | | |

Sequantielly list conditions, if any, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST

| PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Par | i i. |
|--|------|
| | |

| 24a. WAS AN AUTOPSY PERFORMEO? 1 YES 2 PNO | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? |
|--|--|
| | 1 TYES 2 NO |

| | RREO TO MEDICAL | | 26. PLACE OF OEATH (Check only one) | | | | | | | |
|----------------------|----------------------------|--|-------------------------------------|------------------|---------------------------------|---|--|--|--|--|
| EXAMINER? | NO | HOSPITAL: 1 Inpatient 2 ER/Outpatient | 3 DOA | OTHE | R: rsing Home 5 - Residence | 6 ☐ Other (Specify) | | | | |
| 27. MANNER OF DEA | 5 Pending Investigation | 28e. DATE OF INJURY (Month, Day, Year) | 26b. TIMI | E OF URY M | 26c. INJURY AT WORK? 1 YES 2 NO | 28d. DEŞCRIBE HOW INJURY OCCURED | | | | |
| 3 Suicide 4 Homicide | 6 Could not be determined | 26e. PLACE OF INJURY — At h building, etc. (Specify) | ome, ferm, a | treet, fac | ctory, office | 261. LOCATION (Street and Number or Rural Route Number, City or Town, Stete) | | | | |

| | 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(e) end manner ee stated. |
|------|--|
| nne) | |

| and wantetth | MI |) |
|--------------|----|---|
| | | _ |

29c, LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year)

AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

, M . D . PAUL E.PRITCHETT 0 BOX 1317 LA PLATA, MD.

31. DATE FILEO (Month, Day, Year)
DEC 0 3 '90

32. REGISTRAR'S SIGNATURE plia Davidson-Randell 6

DIVISION ATTERMENTS DIRECTOR Hours after 18 HOSPITAL (FUNERAL (WITHIN 72 H TO THE HOSPITA
TO THE FUNERA
De filed within 72
IMPORTANT: 1

| | | F |) | |
|---|---|---|---|--|
| GION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146 | ENDING PHYSICIAN: The law requires that the death certificate be executed within 2—ours after death. Page 6 may be retained by the hospital or attending physician. | R: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should | er death with the State Dept, of Heath and Mental Hygiene prior to burfal, cremation, or removal. | i is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |

DIRECTOR

FUNERAL

BY

LETED

COMPL

BE

CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

2

GRISFLDA

31. DATE FILED (MONTOVOAS 0

FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE STATE REGISTRAR 1 -**CERTIFICATE OF DEATH** REG. NO. 1. DECEDENT'S NAME (First, Middle, Last) 2. DATE OF DEATH 3. TIME OF DEATH 9:45 Am -ILLIAN 90 SMOTHER au 4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday. IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTH 8. BIRTHPLACE (State or Foreign Country) MONTHS DAYS HOURS MIN. 71 1 - M 2 F VRS 4 31 1919 MARYLAND 9s. FACILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF DEATH 9c. COUNTY OF DEATH HARBOR HOSPITAL BALTIMORE RESIDENCE OF DECEDENT 10e STATE 10h COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY MARYLAND ANNE ARUNDEL ANNAPOLIS 1 YES 2 NO 10e STREET AND NUMBER 1115 MADISON ST. APT. S3 101. ZIP COOE 109. CITIZEN OF WHAT COUNTRY? 21403 U.S.A. 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 ☐ YES X X NO WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— I14. RACE — American Indian, if yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Never Merried 2 Merried IF YES, GIVE WAR OR DATES 1 TES 2X NO Specify: Specify: 3. Widowed 4 Divorced BLACK 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 15. DECEDENT'S EOUCATION (Specify only highest grade complete 16b. KIND OF BUSINESS/INQUISTRY NIGHT CLUB Elementary/Secondary (0-12) College (1-4 or 5+) SELF EMPLOYED 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) CHARLES E. SMOTHERS JANIE PRATT 19a, INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1115 MADISON ST. APT. S3 ANNAPOLIS. SARAH WIGGINS 20s. METHOD OF DISPOSITION

10 Parties 2 Cremation 3 Removal from State 20b. PLACE OF DISPOSITION (Name of cemetery, crematory or 20c. LOCATION — City or Town, Stats Donation 5 - Other (Specify) MD. CREST CEMETERY ANNAPOLIS 22. NAME AND ADDRESS OF FACILITY 821 WEST ST. ANNAPOLIS MD. 21401 21, SIGNATURE OF EUNERAL SERVICE LICENSEE Javn REESE & SONS MORTUARY, P.A. 23. PART I. Enter the diseases, or complications that caused the deeth. Do not enter the mode of dying, euch se cardiac or respiratory arrest, Approximata shock, or heart fallure. List only one cause on each line. Interval Between **Onset and Dasth** IMMEDIATE CALISE (Final disease or condition ar carcinoma metastatic OUE TO (OR AS A CONSEQUENCE OF): resulting in death) Sequentielly list conditions, DUE TO (OR AS A CONSEQUENCE OF): if eny, leeding to Immediate ceuse. Enter UNDERLYING CAUSE (Diseese or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS PERFORMED? AVAILABLE PRIOR TO Hegato renal COMPLETION OF CAUSE 1 - YES 2 100 1 - YES 2 1 16 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 YES 2 NO Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. MANNER OF DEATH 26s. DATE OF INJURY 26b. TIME OF 26c. INJURY AT WORK? 26d, DESCRIBE HOW INJURY OCCURED 1 Natural 5 Pending 1 YES 2 NO 2 Accident 28e. PLACE OF NJURY — At home, building, etc. (Specify) 281. LOCATION (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 4 Homicide 29s. CERTIFIER

CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and piace, and dus to the cause(s) and manner as attended. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 29b SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) Brice Resident MD - Ned 90

3001

1990 June Davidson

. HANDVER ST.

21230

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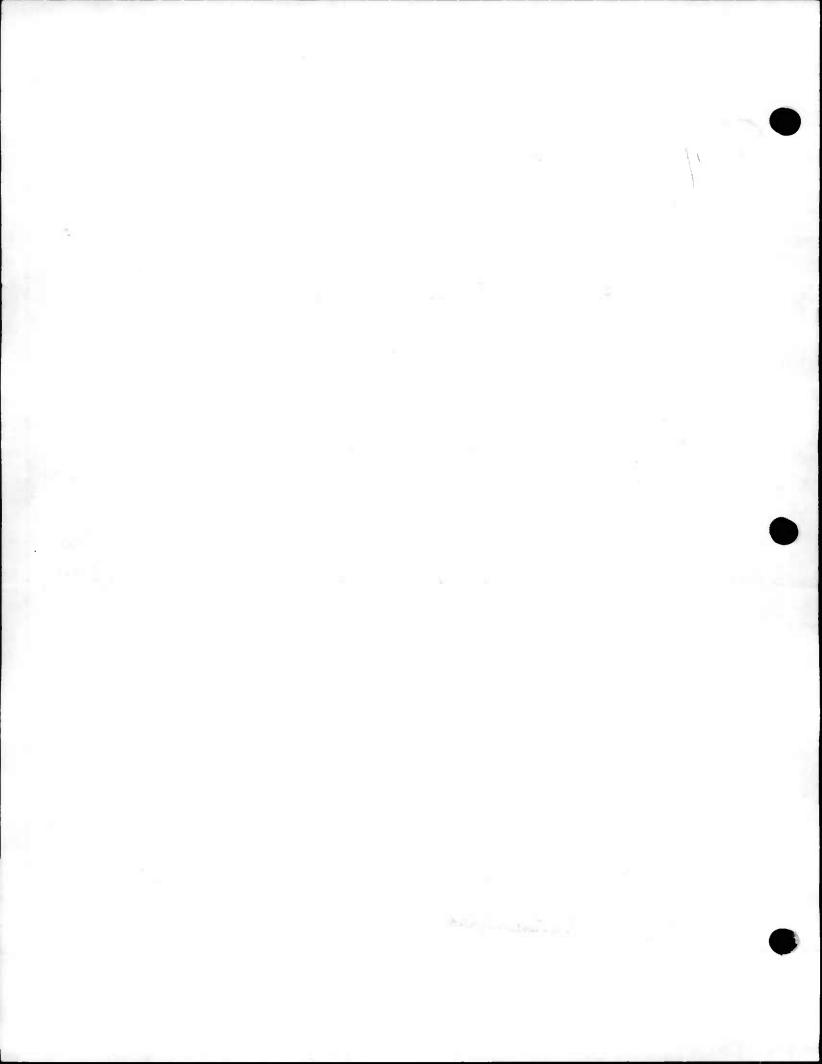
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| | | FOR STATE REGISTRAR | STATE OF MARYL | | | F HEALTH OF DEAT | | TAL HYGIEN REG. NO. | E | | |
|---|---------------|--|--|-------------------------|---------------------------------|-------------------------------|-----------------------------|---|--------------------|-----------------------|--|
| | P | 1. DECEDENT'S NAME (First, Middle, Last) JERRY SRNE | c74 | | | | | ATE OF OEATH ON | | AR | 7 46 A |
| | | 4. SOCIAL SECURITY NUMBER 213-07-4627 | 5. SEX 8. AGE | (In yrs. last birthday) | IF UNDER 1 YE | | MIN. (A | ATE OF BIRTH fonts Dev Mens | 1 ' | SIRTHPLA Country) | CE (State or Foreign |
| 2. 3 should | OB | 9a. FACILITY NAME (If not institution, give str ANNE ARUNDEL MU | edical CEN | ter | ANNA | POSIS | | | 9c. COUNTY ANNE | OF DEATH | |
| Pages 1, 2 | DIRECTOR | RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY | | 10c. CI1 | Y, TOWN OR L | OCATION | | | 41 | | I. INSIDE CITY LIMITS? |
| permit. | | MD ANNE 10e. STREET AND NUMBER | ARUNDEL | ANI | NAPOL. | 101. ZIP CODI | E | | 10g. CITIZEN | 1 | YES 2 NO |
| physician. burial-transit | FUNERAL | 1007 Forest Hi | 12. WAS DECEDENT EYER I | N U.S. ARMED | 13. WAS | 21403 | | RIGIN? (Specify Yes | USA or No- 14. | RACE — | American Indian. |
| retained by the hospital or attending physician. 5 should be detached for use as the burial-tran notified at once, | ВУ | 1 Never Married 2 Married 3 Widowed 4 Olvorced | FORCES? 1 YES | ATES NO | | s, specify Cube YES 2 R NO | n, Mexican, Pur Specify: | rto Rican, etc.) | | Black, Wi Specify: | WHITE |
| al or atten for use as | ETED | 15. DECEDENT'S EDUC (Specify only highest grade of Elementery/Secondery (0-12) | ATION completed) College (1-4 or 5 +) | life. Do NOT L | work done durin se retired.) | PATION og most of workir | og | 18b. KINO OF BU | | RY | |
| the hospita detached f | COMPLET | 8 17. FATHER'S NAME (First, Middle, Last) | | Machin | ist | 18. MOT | HER'S NAME (F | STE | | | |
| ed by the uld be de | BE C | ERNEST SRNEC | | | | AN | MELIA | CHIHAL | | | |
| be retained to be 5 should a notified | 5 | 19a. INFORMANT'S NAME (Type/Print) THELMA L. HIINT | | | | reet and Number | | Number, City or Tow | n, Stete, Zip Coo | | MD. |
| age 6 may be director, page er must be | | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremation 3 Remo | val from State | other place) | | | | 20c. LO | CATION — City | or Town, | State |
| after death. Page 6 may be by the funeral director, page moval. | | 21. SIGNATURE OF PUNERAL SERVICE LICE | | ARELAN | 22. NAN | ME AND ADDRE | SS OF FACILITY | AL HOM | LTIMO | | MD |
| rs after dea n by the fur removal. | | 23. PART I. Enter the diseases, or c | COMME A | d the deeth Do | 12 1 | PIDGEI | V AVE | MHE A | NNAPO | LIS | MD Approximate |
| ted within 2ours after completely filled in by th ial, cremation, or remove : event, the medical | | shock, or hast fellure. I IMMEDIATE CAUSE (Finel disease or condition resulting in death) | | | ray | An | ut | Cardiac of resp | netory arrest | | Interval Batwaen Onset and Deeth |
| execut and to bur | ATION | Sequentielly list conditions, if any, leading to immediate cause. Enter UNDERLYING | QUE TO (OR AS | A CONSEQUENCE | alure | nel 4 | releve | | | | |
| th certificat ending phy il Hyglene p or other | CERTIFICATION | CAUSE (Disease or injury that initiated events resulting in death) LAST | DUE TO (OR AS | A CONSEQUENCE (| OF): | | | | | | |
| and the and Mi | MEDICAL | PART II. Other significant conditions Cerrica hum Partinagem (| s contributing to death i | but not resulting | In the under | rlying csuse | given in Part | I. 24a, WAS AN PERFOI | RMEO? | CO DF | RE AUTOPSY FINDINGS INLABLE PRIOR TO IMPLETION OF CAUSE DEATH? YES 2 NO |
| V: The law icate has b State Dept. | CIAN | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | OTHER: | 26. PLACE OF E | DEATH (Check or | nly one) | | | |
| SICIAN: certifica h the St | PHYSICIAN: | 1 TYES 2 NO 27. MANNER OF DEATH | 1 Sinpatient 2 ER/Out 28a. DATE OF INJURY | 28b. TI | 4 Nursing | Home 5 R | | Other (Specify) . DESCRIBE HOW | NJURY OCCUR | EO | |
| OR ATTENDING PHYSICIAN: The law requires the OIRECTOR: After this certificate has been signed nours after death with the State Dept. of Health tiem 28 is marked, or item 23 shows at | D BY | Netural 5 Pending Investigation 3 Suicide 6 Could not be | (Month, Day, Year) 28e. PLACE OF INJUR building, etc. (Spe | Y — Al home, farm, | | WORK? YES 2 [| | LOCATION (Street City or Town, State | and Number or I | Rural Route | Number, |
| OR ATTER DIRECTOR hours after item 28 | ш | 4 Homicide detarmined | | | | | | | | | |
| E AC = | COMPLET | (ma) | CIAN: To the best of my known: R: On the basis of examination | | | | | | | ause(a) ar | nd manner as stated. |
| TO THE HOSPI TO THE FUNER be filed within IMPORTANT: | TO BE (| 296. SIGNATURE AND TITLE OF CERTIFIER | Mann | | | 29c. LIC | ENSE NUMBER | | 29d. OATE SI | GNED (MC | 7 O |
| | - | 30. NAME AND ADDRESS OF PERSON WHO | GORE | 6001 | 2. del | y Ar | nag | lis | Md | 2 | (40/ |
| | 7 | "NOV 26" 1990 Jul | La Saydson-Right | | V | V | | | | | 7 1 |
| | | | | | | | | | | | DHMH-18 Rev 1/8 |

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| PHYSICIAN: The law requires that the death certificate be executed within 2, nours after death. Page 6 may be retained by the hospital or attending physician. this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 sink the State Dept. of Health and Mental Hyglene prior to burial, cremation, or removal. |
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| | FOR - STATE REGISTRAR | STATE OF M | | DEPAR | | | | | MEN | TAL HYGIENE REG. NO. | | 26 | 34494 |
|---|--|--|-----------------------|--|------------|-------------|-------------------------------------|-------------|---------------|---|--------------|--------------------------|---|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | | | | ATE OF DEATH | | YEAR | 3. TIME OF DEATN |
| | EDWARD | | | SCHMA | LENRE | RGER | | | 1 | | | 90 | 9.28 AM |
| | 4. SOCIAL SECURITY NUMBER | OCIAL SECURITY NUMBER 5. SEX B. AGE (In yrs. lest birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. 7. DATE OF BIRTIN | | | | | | | | | B. BIRTH | IPLACE (State or Foreign | |
| | 498-36-2220 | 1 M 2 F | 64 | YRS. | MONTHS | DAYS | HOURS | MIN. | | 3/28/26 | | IL | |
| | | | | | | | | | 9c. COU | NTY OF D | EATH | | |
| DIRECTOR | NORTH ARUNDFL HOSPITA | | ION | | | N BUF | | | | | ANN | E ARU | NDEL COUNTY |
| E. | 10e. STATE 10b. COUNTY | | | | Y, TOWN | | | | | | | | 10d. INSIDE CITY LIMITS? |
| | | Arunde1 | | Sev | erna | _ | | | | | | | 1 TES 2 NO |
| ₹ I | | | | | | | | 10g. CIT | ZEN OF | WHAT COUNTRY? | | | |
| 9 | 472 London Lane | | | | | | 211 | | | | | SA | |
| BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Wildowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V | YES 2 | | | If yes, spe | | an, Maxica | n, Pus | NGIN? (Specify Yea arto Rican, atc.) | or No— | | |
| | | V | 000 | | | | | | _ | | - 1 | | white |
| COMPLETED | 15. DECEDENT'S EDUC (Specify only highest grade | | (4 | ECEDENT'S Give kind of e. Do NOT u | work done | during mo | on st of world | ing | | 18b. KIND OF BUS | INESS/INC | DUSTRY | |
| ۳ | Elamentary/Secondary (0-12) | College (1-4 or 5 | +) | | | | | | | T.T. a. 1 2 | 1 | | |
| A I | 12 | 4 | | Engir | eer | | | and the | | Westing | | e | |
| | 17. FATHER'S NAME (First, Middle, Last) | | | | | | 0.00 | 200 | | irst, Middle, Meiden S | Surname) | | |
| BE | Edward W. Schmale | nberger | Γ. | | | | | nown | - | | | | |
| 2 | 19a. INFORMANT'S NAME (Type/Print) | , | | | | | nd Numbe | or Rural | Route | Number, City or Town | , State, Zij | p Code) | |
| | Mrs. Midge Schmal | enberger | | Same | | | | | | | | | |
| | 20a. METNOD OF DISPOSITION 1 ## Buriet 2 Cremetton 3 Rem- | oval from State | 20b. PLACE other p | e of dispo place) teran | _ | | | matory or | | Crow. | | | own, Stata MD |
| | 21. SIGNATURE OF FUNERAL SERVICE LIC | ENSEE | , | | | | | ESS OF FA | | | D | 1- D- | |
| | · Aoberts. E | 100 | 1 | | | | | | | Severna 21146 | Par | K FU | neral Home |
| 23. PART I. Enter the diseases, or complications that crused the death. Do not enter the mode of dying, such as cardiac overspiratory arrest, shock, or heart feliure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. | | | | | | | interval Between Onest and Death | | | | | | |
| MEDICAL | PART II. Other algnificant condition | a contributing to | o death but not | resulting | in the u | nderlyin | g cause | given in | Part | i. 24e. WAS AN PERFOR | MED? | 24 | b. WERE AUTOPSY FINDINGS ANAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO |
| AIC. | 25. WAS CASE REFERRED TO MEDICAL EXAMINERY | ноевита | | | 1 | | LACE OF | DEATH (C | heck o | nly one) | | | |
| SK | 1 VES 2 | HOSPITAL: | ER/Outpatient | 3 🗆 DOA | 4 Nu | | 10 5 🗆 F | Residence | 6 🗆 | Other (Specify) | | | |
| 27. MANNER OF DEATH 1 Natural 5 Pending trivestigation 28a. DATE OF tHJURY (Month, Dey, Year) 28b. TIME OF HJURY AT WORK? 1 VES 2 NO 28a. DATE OF HJURY AT WORK? 1 VES 2 NO 28a. DATE OF HJURY AT WORK? 28a. DATE OF HJURY AT WORK? 28a. DATE OF HJURY AT WORK? 28b. DESCRIBE NOW INJURY OF BURY AT WORK? | | | | | | | | CURED | | | | | |
| | | | | | | | | er or Rural | Route Number, | | | | |
| 3 Suicide 4 Homicide 6 Could not be detarmined Duitding, etc. (Specify) City or Town, State) 29a. CERTIFUER (Check only one) 2 MEDICAL EVAILIBLE On the basis of examination anglor investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 29b. LICENSE NUMBER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) | | | | | | | | | | | | | |
| 2 | 30 NAME AND ADDRESS OF PERSON W | HO COMPLETED CA | USE OF DEATH OT | EM 27) (7) | ou, Print) | | | | | | | // - | X 1 1/0 |
| | HILARY OHER IN M.D. | - 325 HO | PITAL PR | IVE.# | 208. | GLEN | BURNI | E. MA | RYL | AND 21061 | | | |



TO BE COMPLETED BY FUNERAL DIRECTOR

| TO BE COMF | TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION |
|--|--|
| i examiner must be notified at once. | IMPORTANT: it item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. |
| the funeral director, page 5 should be detacher val. | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached be filled within 72 hours after death with the State Dept, of Health and Mental Hygiene prior to burial, cremation, or removal. |
| er death. Page 6 may be retained by the hosp | TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within this after death. Page 6 may be retained by the hosp |
| | |

1. IM 1

| 1 - FOR STATE REGISTRAR | STATE OF MARYLA | AND / DEPARTM CERTIFICA | | | | YGIENE EG. NO. | |
|--|---|--|---------------------------|--|---------------------------------------|---------------------------------|---|
| WITLSON ROGERS | | SIMMON | ss. SR. | | 2. DATE OF DECEM | BER 4 | 1 9 9 0 3. TIME OF DEATH 11:40A M |
| 3 SOCIAL SECURITY NUMBER 215-28-7981 | 1 X M 2 □ F 6 | In yrs. lest birthday) WAS. WON | INDER 1 YEAR | IF UNDER 24 HRS. HOURS MIN. | 7. DATE OF B (Month, Day 3-9-19 | 30 | 8. BIRTHPLACE (State or Foreign Country) MARYLAND |
| PHYSICIANS ME | MORIAL HOS | | LA PI | ATA | ATH | 1 111-1 | HARLES |
| 100. STATE 100. COUNTY MARYLAND CHAR | LES | | PLATA | ON | | | 10d. INSIDE CITY LIMITS? 1 TYES 2 1 NO |
| 100. STREET AND NUMBER RT. 2, BOX 2345 | | | | ZIP CODE 0646 | | 10g. C | USA |
| 11. MARITAL STATUS 1 Never Merried 2 Merried 3 Widowed 4 Divorced | 12. WAS DECEDENT EVER IN FORCES? 1 YES IF YES, GIVE WAR OR DA | 2 (X) NO | If yes, spe- | NDENT OF HISPANI city Cuben, Mexican 2 NO Specify: | , Puerto Rican | | 14. RACE — American Indian, Black, White, etc. Specify: WHITE |
| 15. DECEDENT'S EDUC (Specify only highest grade Elementery/Secondary (0-12) | | 16a. DECEDENT'S USU. (Give kind of work of life. Do NOT use reti | done during mos ired.) | t of working | | D OF BUSINESS/ | |
| 7TH GRADE 17. FATHER'S NAME (First, Middle, Last) JOSEPH CLAGGETT | SIMMONS | PAINTER, | G.S.A. | 18. MOTHER'S NAM | | | |
| 190. INFORMANT'S NAME (Type/Print) PAMELA L. MUMFORD | 311110113 | | | d Number or Rural R | loute Number, C | ity or Town, State, | Zip Code) ND 20602 |
| 20r. METHOD OF DISPOSITION 1 O Burlet 2 Cremetton 3 Remo | oval from State | PLACE OF DISPOSITIO | | etery, crematory or | , John , | 20c. LOCATION | - City or Town, State ATA, MARYLAND |
| 21. SIGNATURE OF FUREFUL BENINCE LIC | Hant | > | | | | HUNTT F | FUNERAL HOME, INC. /LAND 20604-0156 |
| 23. PART I. Enter the diseases, price shock, or heart feilure. IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) | List Dniy Dne cause in a | | | | | | Interval Between Onset and Death |
| Sequentielly list conditions, if eny, leeding to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in deeth) LAST | | CONSEQUENCE OF): | | | | | |
| | e contributing to death be NOTIVE | UROPA | | | | PERFORMED? | AVAILABLE PRIOR TO |
| 25. WAS CASE REFERRED TO MEDICAL | | B | 26. PL | ACE OF DEATH (Che | ack only one) | | |
| EXAMINER? | HOSPITAL: | | THER: Nursing Home | 5 Residence | 8 Other (Sp | ectfy) | |
| 27. MANNER OF DEATH 1 Natural 5 Pending 2 Accident Investigation | 28e. DATE DF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | WOI | | 28d. DEŞCRII | BE HOW INJURY | OCCURED |
| 3 Suicide 8 Could not ba 4 Homicide determined | 28e. PLACE OF INJURY building, etc. (Spec | ? — At home, farm, stree city) | t, factory, office | | | N (Street end Nun wn, State) | nber or Rural Route Number, |
| Conden ormy | CIAN: To the best of my know | | | | | | stated. o the ceuse(e) end menner ee stated. |
| 29b. SIGNATURE AND TITLE OF CERTIFIED | maye N | doule | | D 20310 | ABER | 29d. I | DATE SIGNED (Month, Day, Veer) |
| 30. NAME AND ADDRESS OF PERSON WH | | | CHAR | LES PRO | F, BLI | G, SU: | ITE 203 |
| 31. DATE FILED (Month, Day, Year) | 32. ARGISTRAR'S SIGN | ACTA-Randelle | ., ., ., | | | | |

3. TIME OF DEATH

8. BIRTHPLACE (State or Foreign Country)
Maryland

6:53

TO THE HOSPITAL OR A TO THE FUNERAL DIRECT DE filed within 72 hours IMPORTANT: If item

29b. SIGNATURE AND T

30. NAME AND ADDRESS OF

31. DATE FILED (Month, Day,

BE 2 LE OF CERTIFIER

100

1 - FOR STATE REGISTRAR

1. DECEDENT'S NAME (First, Middle, Last)

| - | | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. les | t birthday) | IF UNDER | 1 YEAR | HOURS | 24 HRS, MIN. | 7. DATE OF BI (Month, Day, | Year) | Cour | THPLACE (St | tate or Foreign |
|--|---------------|---|---|------------------------------|----------------------------|----------------|------------|----------------------|-----------------|-------------------------------------|--------------------------------|------------------|---|------------------------------|
| 500 | | 212 - 12 - 6638 | 1 💢 M 2 🗆 F | 70 | YRS. | MONTHS | LANTS | Houns | mirt. | Dec. 0 | 14, 191 | 9 N | Maryla | ind |
| 200 | | 9a. FACILITY NAME (If not institution, give st | treet and number) | | | 9b. CITY | , TOWN C | R LOCATIO | ON OF DEA | ATH | 9c. C | COUNTY OF | DEATH | |
| 9 : | TOR | 9385 North Lawrel | rel Road Laurel | | | | | | | | Howard | | | |
| 100 | DIRECTOR | Maryland Howar | | | | r, town o | OR LOCAT | ION | | | | | 10d, INSI LIMI | IDE CITY ITS? S 2 X NO |
| permit. | | 100. STREET AND NUMBER | Lau | rec | 101 | ZIP CODE | | | 10g. | CITIZEN OF | F WHAT COU | | | |
| sit p | 18 | 9385 North Laurel | Road | | | | | 20723 | | | | - 11 | S A | |
| 3146 ng physician. he burial-transit | BY FUNERAL | 11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced | 12. WAS DECEDEN FORCES? 1 IF YES, GIVE V World W | THE VER IN U.S. AF | IMED NO | | WAS DEC | ENDENT O | F HISPANI | IC ORIGIN? (Sp. n, Puarto Rican, | | — 14. RA | U.S.A. 14. RACE — American Indian, Black, White, etc. Specify: White | |
| 203-31 | 8 | 15. DECEDENT'S EDUC (Specify only highest grade | CATION | 16a, DE | CEDENT'S live kind of w | USUAL O | CCUPATIO | ON est of working | g | 18b. KIND | OF BUSINESS | /INDUSTRY | | |
| MARYLAND 212 retained by the hospital or 5 should be detached for u notified at once. | COMPLET | Elamentary/Secondary (0-12) Grade 11 | College (1-4 or 5 | +) | uck D | | | | | u.s. | Gover | nnent | (Ft. | Meade) |
| the hos detach | | 17. FATHER'S NAME (First, Middle, Last) | , | | | | | | | ME (First, Middle, | , Maiden Surnan | 10) | | |
| Ned by uld be ed at | | Norman C. Smallwo | ood | | | | | | | Jones | | | | |
| MARY retained 5 should | 일 | Alice H. Smallwoo | rd | | | | | | | oute Number, CI | | | | 703 |
| RE, Respectively. | | 20a, METHOD OF DISPOSITION | - | 20b. PLACE | | | | | | | 20c. LOCATION | | | 123 |
| O D B G I I I I I I I I I I I I I I I I I I | | 1 M Burial 2 Cremation 3 Ram 4 Donation 5 Other (Specify) | oval from Stata | other pi | n Cen | | | | • | - 1 | | | | ryland |
| BALTINORE, MARYLAND 21203-3146 stee death. Page 6 may be retained by the tuneral director, page 5 should be detached for use as the burnoval. cal examiner must be notified at once. | | 21. SIGNATURE OF FUNERAL SERVICE LIC | ensee On a | Chen | | 22. | name ai | | . Fun | | ome, P | .A. | | |
| by by | | 23. PART I. Enter the diseases, or a shock, or heart fellure. | complications the | at caused the de | ath. Do n | | | | | | | | Ap | proximate |
| tion. | | IMMEDIATE CAUSE (Final disease or condition | Liat only one ca | 1 | | Aor | . O | usa | Mic | ine | | | | arvel Between |
| 46, ompletely fine side, cremation, event, the | | reaulting in death) | b. DUE TO (OR AS A CONSEQUENCE OF): Metastatic Cancinoma | | | | | | | | 10 | | | |
| 13146, executed will and comple b bunial, cre matic ever | | Sequentially list conditions, | b | 0 | Uta. | ota | HC | Ca | ricen | coma | . ' | | | m. |
| Ser to be | I E | If any, leading to immediate cause. Enter UNDERLYING | DUE TO (OR AS A CONSEQUENCE OF): | | | | | | | | | | | |
| ertificate be en fing physician region to other traum | 5 | CAUSE (Disease or Injury that initiated events | cDUE TO | TO (OR AS A CONSEQUENCE OF): | | | | | | | | - i - | | |
| O ta giga s | CERTIFICATION | reaulting in death) LAST | d. | | | | | | | | | | | |
| S, P. e death he atten Mental Hury. o | | PART II. Other significent condition | a contributing to | deeth but not | resulting | in the u | nderlyin | a cause c | alven in i | Part I 24a | . WAS AN AUTO | pev (| 245 WEDE AL | JTOPSY FINDINGS |
| RECORDS, F w requires that the dea been signed by the att of. of Health and Menta 3 shows any Inlury. | MEDICAL | | | Justin Bat Hot | | iii uio u | | g coust § | giveir iii i | | PERFORMED? | | AVAILABI | LE PRIOR TO TION OF CAUSE |
| PECO requires t een signer of Health | | | | | | | | | | _ ' | YES 2 N | ° | OF DEAT | 'H? S 2 □ NO |
| St. of search | 2 | | | | | | | | | _ | | | 10.10 | |
| has has | ICIAN: | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | 100000 | | | | | LACE OF D | EATH (Che | ock only one) | | | | |
| F VITA SICIAN: Th certificate the State the State the State the State the State the State the State the State the State the State the State the State the State | rsic | 1 YES 2 NO | HOSPITAL: | ☐ ER/Outpetient | B □ DOA | OTHE 4 Nu | | ne 5 🗆 Re | esidence i | 8 Other (Spe | ecify) | | | |
| OF VITAL PHYSICIAN: this certifical with the St | PHYSI | 27. MANNER OF DEATH 1 Natural 5 Pending | 26a. DATE Of (Month, | F INJURY Day, Year) | 28b. TIM | E OF | W | JURY AT ORK? | | 28d. DESCRIB | E HOW INJURY | OCCURED | | |
| ING PHYSIC OF CASH THIS CA | B | 2 Accident Investigation | 200 DI ACE | OF INJURY — At h | ama fama | M des | | YES 2 | NO | 201 1 0017101 | M (Street and Mr. | | -1 O | |
| TTEND TOR: 4 after d | TED | 3 Suicide 6 Could not be 4 Homicide detarmined | | , atc. (Specify) | onre, rarm, | etroot, fac | aory, ome | | | City or Tox | N (Street and Nu wn, State) | moer or Hun | III PIOUTE NUM | Der, |
| DIV L OR A L DIREC Phours | PLE | (Orlook Orly) | ICIAN: To the best o | of my knowledga, d | esth occurr | ed at the | time, date | and place | , and dua | to the cause(a) | and manner as | a stated. | 7 | |
| HOSPITAL FUNERAL WITHIN 72 | O. | MEDICAL EXAMINE | ER: On the beals of | examination and/or | investigation | on, In my | opinion, | death occur | red at the | time, data and | placa, and dua | to the caus | and mar | nner as stated. |
| 五 5 4 4 | U | ON DESCRIPTION AND THE OR OF STREET | | | | _ | | T | | | 1 | | + . | |

ia Davidson-1

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO.

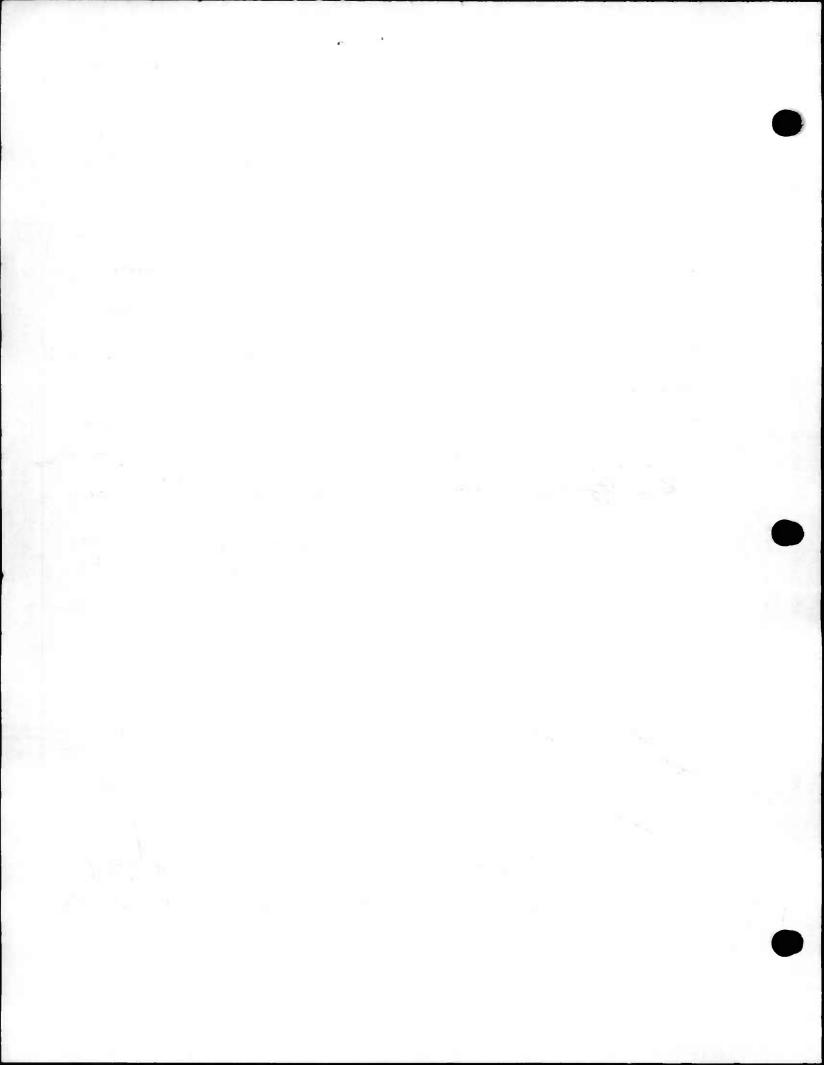
ROLAND CLIFTON SMALLWOOD

2. DATE OF DEATH MONTH November

28,

1990

DHMH-16 Rev 1/89



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 nours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burlat-transit permit. Pages 1, 2, be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burlat, cremation, or removal. IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. FOR STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE

| | 1 - STATE REGISTRAR | OMIL OF I | C | ERTIF | ICATE O | F DEATH | F | REG. NO | | | | |
|---|--|---|------------------------|---------------|------------------|--|------------------|-------------|------------------------------|------------------|--|----------------|
| | 1. OECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF | DEATH | | YEAR | 3. TIME OF DEAT | |
| | MAE | ANNA SIL | BERGELD | | | | NOV | | | YEAR | 4:15 | A _M |
| | 4. SOCIAL SECURITY NUMBER | 5. SEX | 6. AGE (In yrs. is | ast birthday) | IF UNDER 1 YEAR | | 7. DATE OF I | BIRTH | | 8. BIRTI | HPLACE (State or Fo. | reign |
| | 296-18-0979 | A DE LOCAL MAN MAN MAN MAN MAN MAN MAN MAN MAN MAN | | | | | | | 23 | OH | | |
| | | CILITY NAME (If not institution, give street and number) 9b. CITY, TOWN OR LOCATION OF | | | | | | | | INTY OF C | | |
| FUNERAL DIRECTOR | 11. 977 91. | | | | | | | | GOMERY | | | |
| EC | | | | | | | | | | 10d. INSIDE CITY | | |
| 吉 | | | | | | | | | 1 YES 2 | NO | | |
| A I | | | | | | | | | WHAT COUNTRY? | | | |
| | 10704 CLERMONT A | VENUE | | | | 20896 | -0377 | | IIN | TTED | STATES | |
| 5 | 11. MARITAL STATUS | 12. WAS DECEDE | | | | ECENDENT OF HISPA | NIC ORIGIN? (S | | | 14. RAC | E — American India | m, |
| | 1 Never Married 2 K Merried | | MAR OR DATES | NO | | specify Cuben, Mexic ES 24 NO Speci | | n, etc.) | | Spec | | |
| 2 | 3 Widowed 4 Olvorced | | | | | | | | | | WHITE | |
| 3 | 15. DECEOENT'S EDI (Specify only highest grad | UCATION le completed) | (| Give kind of | work done during | TION most of working | 16b. KII | ND OF BU | SINESS/IN | DUSTRY | | |
| ų l | Elementery/Secondery (0-12) | College (1-4 or 5 | - 40 | fe. Do NOT u | ise retired.) | | | | | | | |
| COMPLEIED | | 5± | PI | YSIC | IST | | | | | | | |
| 5 | 17. FATHER'S NAME (First, Middle, Last) | | | | | 16. MOTHER'S NA | AME (First, Midd | lle, Maiden | Surname) | | | |
| | WILLIAM | DRISCOLL | | | | | JENN | IE S | MITH | | | |
| | 19e. INFORMANT'S NAME (Type/Print) | | 1 | 9b. MAILIN | AOORESS (Street | et and Number or Rural | Route Number, | City or Tow | vn, State, Z | ip Code) | | |
| 2 | SAM SILBERGELD | | | 107 | 04 CLER | MONT AVE. | GARR | ETT | PARK | . MD | 20896-0 | 377 |
| | 20a. METHOD OF DISPOSITION | | 20b. PLACI | E OF DISPO | | cemetery, crematory or | | | | | own, State | |
| | 1 Denetion 5 Other (Specify) | moval from State | Mary | land | State | Anatomy B | oard | Ba | ltim | ore. | Md. | |
| | 21. BIGNATURE OF FUNERIAL SERVICE L | ICENSEE . | 7 | | 22. NAME | ANO ADDRESS OF F | ACILITY | | | | | |
| | > Low | 100/ | 1 | | | y L. Kauf | | | | | | |
| | 23. PART I. Enter the diseases, or | ya | | | | Main St | | | | | . 21227 Approxim | |
| ahock, or hear failure. List only one cause on aach lina. IMMEDIATE CAUSE (Final disease or condition resulting in daeth) a. METASTATIC BREAST CARCINOMA Due to (or as a consequence of): Sequentielly list conditions, if any, leeding to immediata ceuse. Enter UNDERLYING CAUSE (Disease or injury that initieted evante resulting in daeth) LAST Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 1 | | | | | | | | Onset end | I Deeth | | | |
| FRIFIC | ceuse. Enter UNDERLYING CAUSE (Dissess or injury that initieted evente resulting in death) LAST | d | O (OR AS A CONS | EOUENCE (| DF): | | | | | | | |
| MEDICAL | PART II. Other eignificent condition | one contributing to | o daeth but not | t resulting | in tha underly | ring ceuea given in | | | N AUTOPSY RMED? 2 X NO | 24 | b. WERE AUTOPSY F AVAILABLE PRIOR COMPLETION OF O OF DEATH? | CAUSE |
| ž | | | | | | | | | | | | |
| 5 | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? | HOSPITAL: | | | OTHER: | PLACE OF DEATH (C | theck only one) | | | | | |
| 2 | 1 TYES 2 NO | | X ER/Outpatient | 3 🗆 DOA | | lome 5 🗆 Residence | 6 🗆 Other (S | (pecify) | | | | |
| PHYSICIAN: ME | 27. MANNER OF DEATH | 26e. DATE O (Month, | F INJURY Day, Year) | 28b. TI | ME OF 26c. | INJURY AT WORK? | 26d, OEŞCR | IBE HOW | INJURY O | CCURED | | |
| BY | 1 Netural 5 Pending 2 Accident Investigation | | | | M 1 [| YES 2 NO | | | | | | |
| | | | | | | | | | | | | |
| COMPLETED | CONDUM ONLY | | | | | late and place, and du | | | | | (e) end manner ee s | tated. |
| BEC | Th. MONATURE AND TITLE OF OF | 7.1.1011 | A LCD | EMI | usu | 29c. LICENSE N | JMBER | | 29d. D/ | TE SIGNE | D (Month, Day, Year) | |
| | July 11:4 | rumen | 10 | | | 157688 | (NY) | | 1 2 | 26h | 10V90 | |
| 2 | 30. NAME AND ADDRESS OF PERSON V | VHO COMPLETED CA | USE OF OEATH (IT | TEM 27) (Typ | oe, Print) | NATIONAL | NAVAL | MEDI | CAL | CENT | ER | |
| | J. N. FRAME, | LCDR. MC. | USN | | | BETHESDA, | | | | | | |
| | 31. OATE FILEO (Month, Day, Year) | | AR'S SIGNATURE | | | | | | 2 2 0 0 | | | |
| | WW 50'90 | 5.50 | Day Bon- | Bandal | 2 | | | | | | | |

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3. TIME OF DEATH

REG. NO

2. DATE OF DEATH

| | - | |
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| | Sec. | V. |
| 14 | | B |
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| , | | - 18 |
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BALTIMORE, MARYLAND 21203-3146

DIRECTOR

FUNERAL

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COMPL

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CERTIFICATION

MEDICAL

PHYSICIAN:

BY

COMPLETED

BE

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iours after death. Page 6 may be retained by the hospital or attending physician. If in by the funeral director, page 5 should be detached for use as the burial-trar TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be to filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to bunial, cremation, or removal.

MPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at it HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 223

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

T/+ 4 0946 A 4. SOCIAL SECURITY NUMBER 5. SEX 7. DATE DE BIRTH (Mojeth, Day, Year) IF UNDER 1 YEAR 8. BIRTHPLACE (State or Foreign Country) IF UNDER 24 HRS. 214-72-1 M 2 WF 02/ 8 8 96. CITY TOWN DR LOCATION OF DEATH 9c. CDUNTY DF DEATH 9a. FACILITY NAME_(If not institution, 8032 CEDENT RESIDENCE OF DE 10a. STATE 10c. CITY, TOWN OR LOCATION 10b. COUNTY 10d. INSIDE CITY MA 1 YES 2 ND 13ACTIMORE 10e. STREET AND NUMBER 10L ZIP CODE 10g. CITIZEN OF WHAT COUNTRY? 21226 2 FORT SMALL USOFD

12. WAS DECEDENT EVER IN U.S. ARMED
FORCES? 1 YES 2 KNO
IF YES, GIVE WAR OR DATES

13. 1 USA 11. MARITAL STATUS 13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yea or No-14. RACE — American Indian, Black, White, atc. If yes, specify Cuban, Maxican, Puarto Rican, etc.)

1 YES 2 NO Specify: 1 Never Married 2 🔀 Married Specify: 3 Widowed 4 Divorced white 15. DECEDENT'S EDUCATION 16a. DECEDENT'S USUAL OCCUPATION 16b. KIND OF BUSINESS/INDUSTRY (Specify only highest grade completed) (Give kind of work done life. Do NOT use retired.) Elementary/Secondary (0-12) College (1-4 or 5+) K-11 Home Ough DUSEWIFE 17. FATHER'S NAME (First, Middle, Last) 16. MOTHER'S NAME (First, Middle, Maiden Surname) ComB OMER ATRICIA 19a. INFORMANT'S NAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR OMER COMB 21043 20s METHOD OF DISPOSITION
1 Surial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ... 20c. LOCATION — City or Town, State 29b. PLACE OF DISPOSITION (Name of cemetery, cremetory or , MA COMETERY AA 22. NAME AND ADDRESS OF FACILITY MO535 SUACKE, H. BOX ZUTELLICONCITY MD 21043 IRT I. Enter the discessed, or complications that coused the deeth. Do not enter the mode of dying, such as cardiac or respiratory street, shock, or heart-failure. List only one cause on each line. Approximate Interval Between Onset and Death MEDIATE CAUSE (Final resulting in deeth) DUE TO (OR AS A PONSE ress Sequentially list conditions. NUMBERCE OF If any, leading to immediate cause. Enter UNDERLYING CAUSE (Disesse or Injury DUE TO (OR AS A CONSEQUENCE OF): that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE 24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO OF DEATH? I YES 2 NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER?

15 YES 2 ND

27. MANNER OF DEATH 26. PLACE OF DEATH (Check only one) OTHER: 1 | Inpatient 2 | ER/Outpatient 3 | DOA ng Home 5 Masidence 8 - Other (Specify) 4 - Nurs 28a, DATE OF INJURY 28c. INJURY AT WORK? 28h TIME OF 28d. DESCRIBE HOW INJURY OCCURED INJURY 1 Natural Se 5 Pending 1 YES 2 NO ung 2 Accident
3 Suicide
4 Homicide Investigation 28e. PLACE OF INJURY — At home, farm, street, factory, office building, atc. (Specify) 281. LOCATION (Street and Number City or Town, Stelle) 8 Could not be determined 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. # DEDICAL EXAMINER: On the basia of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(a) and manner as stated. 290. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 10 0 HO COW LETED CAUSE OF DEATH (ITEM 27) (Type, Frint, MD ONES 31. DATE FILED (Month, Day, Year) 32. REGISTRAR'S SIGNATURE Tilon-Rendell 9 101

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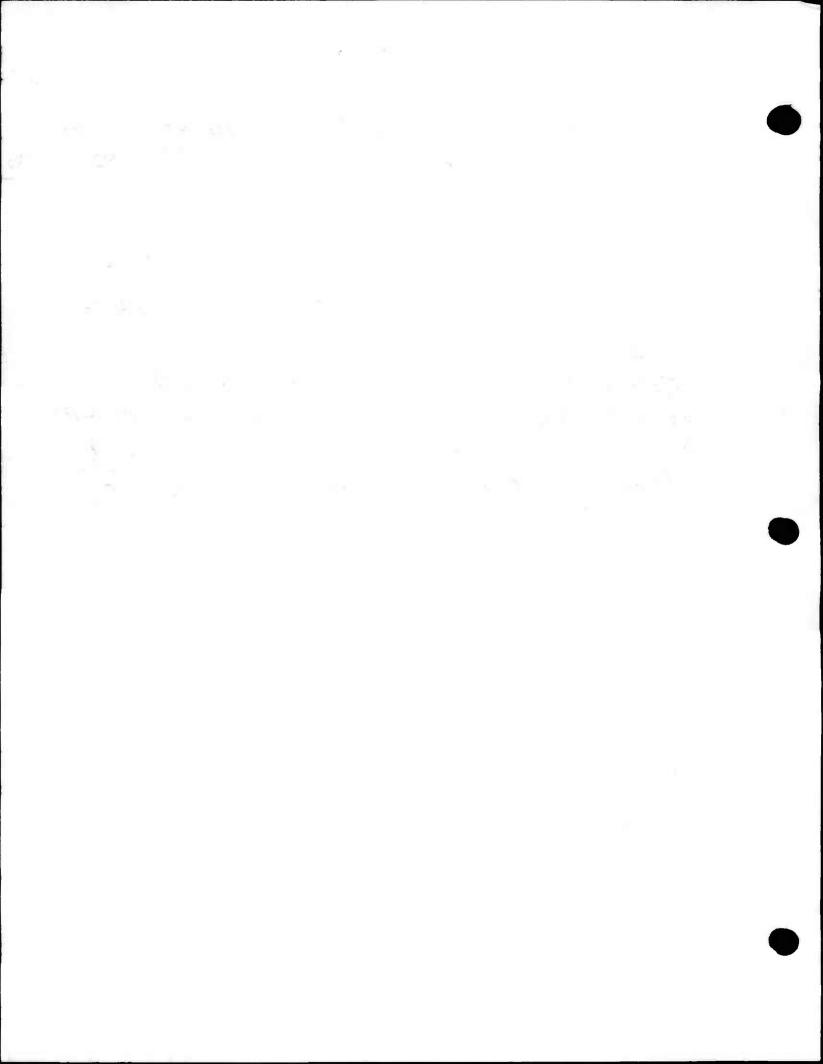
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BALTIMORE, MARYLAND 21203-3146

| ter death. Page 6 may be retained by the hosp | the funeral director, page 5 should be detached oval. | al examiner must be notified at once. | |
|---|---|--|--|
| TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 Tours after death. Page 6 may be retained by the hosp | TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached the filed within 72 hours after death with the State Dept. of Heath and Mental Hyglene prior to burial, cremation, or removal. | IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once. | |

| STATE OF MAI | RYLAND / DEPARTM CERTIFICA | ENT OF HEALTH | | YGIENE EG. NO. |
|--------------|-------------------------------|---------------|--------------|-------------------|
| fle, Last) | C. 12 | 1/0 | 2. DATE OF D | EATH DAT |

| | REGISTRAR CERTIFICATE OF DEATH REG. NO. | | | | | |
|---|--|--|--|--|--|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) SOPHIE M. SIEKIERSKI 2. DATE OF DEATH MONTH 125 190 YEAR SIEKIERSKI MONTH 125 190 YEAR SIEKIERSKI | | | | | |
| OR | 4. SOCIAL SECURITY NUMBER 212-05-078 51 8. SEX 6. AGE (In yrs, lest birthday) F UNDER 1 YEAR F UNDER 24 HRS. 7. DATE OF BIRTH (Month, Day, Year) 9/4 8. BIRTHPLACE (State or Foreign Months) Months DAYS Moures Min. 05-15- MD | | | | | |
| | 9a. FACILITY NAME (If not institution, give street and number) CHRRCH HOSPITAL CORP. 9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY 9c. COUNTY OF DEATH | | | | | |
| ᄗ | RESIDENCE OF DECEDENT 10s. STATE 10b. COUNTY 10c. CITY, TOWN OR LOCATION 10d. INSIDE CITY | | | | | |
| PIR | MD BALTIMORE LIMITS? 1 □ Yes 2 □ NO | | | | | |
| COMPLETED BY FUNERAL DIRECTOR | 737 S LINWOOD AVE 101. ZIP CODE 21224 109. CITIZEN OF WHAT COUNTRY? 2.1224 | | | | | |
| | 11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, atc.) 14. RACE — American Indien, Black, Whita, atc. 15. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, atc.) 16. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, atc.) 17. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, atc.) 18. Was DECENDENT OF HISPANIC ORIGIN? (Specify Yea or No— Black, Whita, atc.) | | | | | |
| | 15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 16b. KIND OF BUSINESS/INDUSTRY | | | | | |
| Ž | 3 HOUSEWIFE | | | | | |
| BE CC | 17. FATHER'S NAME (First, Middle, Last) TO SED H KOWALEWSKI KOSE CHINSLA | | | | | |
| 5 | 19a. INFORMANT'S VAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19c. INFORMANT'S VAME (Type/Print) 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 137 S. Linwood AVE. BAUTO. MD-21724 | | | | | |
| | 20s. METHOD OF DISPOSITION 1 Burtal 2 Cremation 3 Removal from State 20s. PLACE OF DISPOSITION (Name of cemetery, crematory or Donation 5 Other (Specify) 20s. PLACE OF DISPOSITION (Name of cemetery, crematory or Donation 5 Other (Specify) 20s. PLACE OF DISPOSITION (Name of cemetery, crematory or Donation 5 Other (Specify) | | | | | |
| | 22. NAME AND ADDRESS OF FACILITY SKALDA F. H. 2829 HUDSON ST | | | | | |
| | 23. PART i. Enter the disesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate | | | | | |
| | shock, or heart failure. List only one cause on each line. iMMEDIATE CAUSE (Final Onset and Death | | | | | |
| | disease or condition a. CANDINGSWIC SIJOCIC | | | | | |
| | DUE TO (OR AS A CONSEQUENCE OF): | | | | | |
| z | LEPINATORY FAILURE | | | | | |
| CERTIFICATION | Sequantially list conditions. | | | | | |
| <u>১</u> | if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury c | | | | | |
| 胎 | that initiated events DUE TO (OR AS A CONSEQUENCE OF): resulting in death) LAST | | | | | |
| H | d. | | | | | |
| | PART II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 24s. WAS AN AUTOPSY 24b. WERE AUTOPSY FINDINGS | | | | | |
| EDICAL | PERFORMED? AVAILABLE PRIOR TO COMPLETION OF CAUSE | | | | | |
| | 1 YES 2 NO OF DEATH? | | | | | |
| Σ | 1 YES 2 NO | | | | | |
| PHYSICIAN: | 25. WAS CASE REFERRED TO MEDICAL 26. PLACE OF DEATH (Check only one) | | | | | |
| Sic | EXAMINER? 1 YES 2 NO OTHER: OTHER: 4 Nursing Home 5 Residence 8 Other (Specify) | | | | | |
| Ħ | 27. MANNER OF DEATH 28s. DATE OF INJURY 28b. TIME OF 28c. INJURY AT 28d. DESCRIBE HOW INJURY OCCURED | | | | | |
| | 1 M Netural 5 Pending (Month, Day, Year) INJURY WORK? 2 Accident Investigation M 1 YES 2 NO | | | | | |
| BY | 3 Sulcide 28e. PLACE OF INJURY — At home, farm, street, factory, office 28f. LOCATION (Street and Number or Rural Route Number, | | | | | |
| 3 Suicide 6 Could not be detarmined building, stc. (Specify) 29a. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, date and place, and due to the cause(a) and manner as a stated. | | | | | | |
| 9 | 29a. CERTIFIER (Check only 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | |
| M | (Check only one) 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(a) and manner as stated. | | | | | |
| 29c. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER 29c. LICENSE NUMBER | | | | | | |
| BE | Court & C. T. M. D. | | | | | |
| 2 | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) | | | | | |
| | Irene Ibarro - Church Hospital - 100 N. Broadway, Balto, Md. | | | | | |
| | 31. DATE FILED (Mornin, Dey, Year) 32. REGISTRAR'S SIGNATURE | | | | | |
| | NUV 20 91 Julia Variation - Annales | | | | | |



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 25—50 or after death. Page 6 may be realised by the investment that the death of the size as the burishment permit. Pages 1, 2,6 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be netitied at once.

DR

31. DATE FILED (Month, Day,

190

| 1 - STATE STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH REG. NO. | | | | | | | | | |
|---|--|--------------------------------|-------------------------------|-------------|--------------------|-------------------------------|---|--------------------|--|
| | 1. DECEDENT'S NAME (First, Middle, Last) | | | | | | 2. DATE OF BEATH | Y YE | 3. TIME OF DEATH |
| 1 | PETER G. STOF. 4. SOCIAL SECURITY NUMBER | | | | | | 11/21/ | 90 | 9 m |
| ١ | 100_05_5474 | 5. SEX | 3. AGE (In yrs. lest birthda) | MONTHS | | OURO MIN. | 7. DATE OF BIRTH (Month, Day, Year) 1-17-1 | | BIRTHPLACE (State or Foreign Country) |
| υı | 9e. FACILITY NAME (If not institution, give stre | et end number) | | 9b. CITY | TOWN OR | LOCATION OF D | | 9c. COUNTY | OF DEATH |
| DIRECTOR | CHURCH HOSPITA | L CORPO | RATION | | BAI | TIMOF | RE CITY | 10 | |
| EC | RESIDENCE OF DECEDENT 10e. STATE 10b. COUNTY | | 10c. C | | OR LOCATION | | | | 10d. INSIDE CITY LIMITS? |
| | MD | | | BALTIMORE C | | | ITY | | 1 YES 2 NO |
| FUNERAL | 100. STREET AND NUMBER 101. ZIP CODE 831 S. KENWOOD AVENUE | | | | 10g. CITIZEN | OF WHAT COUNTRY? | | | |
| NS I | | | EYER IN U.S. ARMED | 13. | WAS DECEN | 21224 DENT OF HISP | ANIC ORIGIN? (Specify Ye | or No- 14. | RACE — American Indian, |
| BY F | 1 Never Married 2 Merried 3 Wildowed 4 Divorced | IF YES, GIVE WA | | | | NO Spec | can, Puerlo Rican, etc.) | | Black, White, etc. |
| | 15. DECEDENT'S EDUCA | TION U | 16e. DECEDENT | 'S USUAL O | CCUPATION | | 16b, KIND OF BU | SINESS/INDUST | WHITE |
| ETE | (Specify only highest grade or Elementary/Secondary (0-12) | | (Give kind | | during most o | of working | - | | |
| COMPLETED | 12 | | GL | A55 | Cu | TIER | | G.I | NC. |
| 190. INFORMANT'S NAME (Strat/Print) 190. INFORMANT'S NAME (Strat/Print) 190. INFORMANT'S NAME (Strat/Print) 190. INFORMANT'S NAME (Strat/Print) | | | | | | | | | |
| | | | | | | 50) | | | |
| ٥ | FRANCES V. S. | TOPANIC | K 831 | 15. | KENU | NOOD , | ALK. BA | 70. | MD-21224 |
| | 20e. METHOD OF DISPOSITION 1 Burlel 2 Cremetion 3 Remove 4 Donetion 5 Other (Specify) | val from State | 20b. PLACE OF DISP | OSITION (Ne | ame of cemen | ery, cremetory or | 20c. LC | CATION — City | or Town, State |
| | 21. SIGNATURE OF FUNERAL SERVICE LICE | NSEE | 0 1 | 22. | NAME AND | ADDRESS OF F | FACILITY | | 20.70 |
| | thomas J. | Sta | de f. | S | KARDI | 9 F.H | . 28291 | FUDSO | NST. |
| | 23. PART I. Enter the diseases, or co ehock, or heart feilure. Li | | | not enter | the mode | of dying, su | ich se cerdiec or reep | Iratory arrest | , Approximete intervel Between |
| | IMMEDIATE CAUSE (Finel disease or condition resulting in deeth) • COWNMY ANTNY DISCIPSE | | | | | | | | |
| | | | | | | | | | |
| Z | Sequentially list conditions, DUE TO (OR AS A CONSEQUÊNCE OF): Consequence of the conditions of th | | | | | | | | |
| ATI | If eny, leeding to immediate ceuse. Enter UNDERLYING | DUE TO (C | OR AS A CONSEQUENCE | OF): ' | | | | | |
| | CAUSE (Disease or Injury that initiated events | DUE TO (C | OR AS A CONSEQUENCE | OF): | | | | | |
| CERTIFICATION | resulting in deeth) LAST | | | | | | | | |
| | PART II. Other significent conditions | contributing to d | leeth but not resulting | g in the u | nderlying o | ceuse given i | | N AUTOPSY RMED? | 24b. WERE AUTOPSY FINDINGS AWAILABLE PRIOR TO |
| DICAL | | | | | | | 1 _ YES | | COMPLETION OF CAUSE OF DEATH? |
| | 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 | | | | | | 1 TYES 2 NO | | |
| Ä | | | | | | | | | |
| SICI | EXAMINER? 1 YES 2 NO HOSPITAL: 1 Minimum 2 ER/Outpettent 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) | | | | | | | | |
| 표 | 27. MANNER OF DEATH | 26e. DATE OF II (Month, De) | NJURY 26b. (Year) | TIME OF | 26c. INJUR WORK | Y AT | 28d. DESCRIBE HOW | INJURY OCCUP | RED |
| 2 Accident Investigation 28s PLACE OF IN HIBY At home from street fectors office 28s I CCATION (Street and Alumber of Russ) | | | | | | | | | |
| | | | | | | Hural Route Number, | | | |
| 'n | Suicise 4 — Homicide detarmined building, etc. (Specify) 29e. CERTIFIER (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the cause(e) and | | | | | | | | |
| (Check only one) 2 MEDICAL EXAMINER: On the best of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(e) | | | | | | ause(e) and manner ea atated. | | | |
| BE C | 296 SIGNATURE AND TITLE OF CERTIFIER | MI) | | | 2 | 9c. LICENSE N | UMBER | 29d. DATE S | IGNED (Month, Day, Year) |
| 70 B | 30. NAME AND ADDRESS OF PERSON WHO | COMPLETED CALLS | F OF DEATH STEM AT C | me Pri-n | | 1 | ' /P | > // | 121190 |
| | ■ JU. NAME AND ADDRESS OF PERSON WHO | COMPLETED CAUSE | E UF DEATH (ITEM 27) /7 | roe, Print) | | | • | | |

BROADWAY

WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

-Mandall

32. REGISTRAN'S SIGNATURE

